Medi-Cal Specialty Mental Health Services: Public Comments/Responses

A public comment period of over 45 days was observed ending with a public hearing on September 16, 2005. The oral and written comments were considered and have been incorporated into the Final Statement of Reasons. Based upon the public comments, the proposed regulations were amended to include changes to Subchapter 5, Sections 1850.205 and 1850.207, to reflect recent changes in the beneficiary processes related to the receipt of Aid Paid Pending. Additionally, the regulations were amended at 1850.225 to reflect changes in Code of Federal Regulations (CFR) Section 438.114(d)(ii) to clarify that providers have ten calendar days of the date the beneficiary presented for emergency services in which to notify the MHP.

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PAI 1-17 Daniel Brzovic, Protection & Advocacy, Inc. (PAI), September 16, 2005

CMHDA 1-2b Patricia Ryan, California Mental Health Director's Association (CMHDA), September 15, 2005

NAMI 1-15 Karen H. Henry, J.D., National Alliance for the Mentally Ill (NAMI,Ca.) September 15, 2005

CMA 1-31 Jack Lewin, M.D., California Medical Association (CMA), September 16, 2005

CHA 1-48 Sheree Kruckenberg, California Hospital Association, September 16, 2005

CASRA 1 Betty Dahlquist, MSW, CPRP, Executive Director, California Association of Social Rehabilitation Agencies (CASRA)

County of L.A. 1 Dr. Marvin J. Southard, D.S.W., County of Los Angeles,

Director of Mental Health, September 16, 2005 (Marvin Southard)

CPA 1-38 Elizabeth Galton, M.D., California Psychiatric Association (CPA), September 16, 2005

CACFS 1-10 Nicette Short, California Alliance of Child and Family Services (CACFS), September 16, 2005

AAMFT-CA.1 Olivia Loewy, PhD, Executive Director, American Association for Marriage and Family Therapy (AAMFT), California Division, August 17, 2005

OCHCA 1-2 David A. Horner, Ph.D., County of Orange Health Care Agency (David Horner), September 16, 2005

Ed Haney 1 RN and Former Employee of Los Angeles County, August 4, 2005

General Comments

Comment: PAI-1 indicates it assumes comments it submitted on December 29, 1997, and December 30, 1997 are contained in this rule-making process. In addition, PAI indicates it appreciates the changes that the Department did make in the proposed regulations.

Response: The Medi-Cal Specialty Mental Health Services regulations have existed in emergency status since November 11, 1997. In 1997, and again in 1999, the regulations were redrafted and copies were put forth for public comment. Neither the 1997 package nor the 1999 package were filed with the Secretary of State, and thus the regulations were not enacted. PAI is correct that many of the comments received during previous regulatory proceedings were incorporated into this regulation package. However, this current regulation package is new. PAI is not correct that the complete content of all previous input which it had provided to the Department is incorporated into this response to public comment.

Comment: CMHDA-1 comments that overall, the regulations and systems that have been developed by county Mental Health Plans (MHPs) have worked well, and have led to a more community-based coordinated and accessible Medi-Cal mental health system in California.

Response: The Department thanks CMHDA for its comments.

Comment: NAMI-1 used several overriding principles in reviewing the regulations, including consideration of the fact that most of the provisions in the new proposed regulations are carried forward from the Department's existing Title 9 regulations. NAMI indicates it makes no distinction of this and only presents recommendations as to any current or new section of the regulations that it determines to be of significant concern.

Response: The Department appreciates NAMI's approach to the review.

Comment: CMA-1 comments that it believes that the medical care provided to Medi-Cal beneficiaries under the consolidated Medi-Cal Mental Health Program must be physician directed, and expresses concern that the regulations lack this input. CMA supports changing the regulations to reflect the need for physician input to the diagnoses of any medical necessity determination. CMA also urges that a plan-appointed medical director be the ultimate word on the denial of care to any patient receiving specialty mental health services.

Response: To the extent that the Department understands this question, it has responded to CMA's concerns throughout the comments listed below. The Department would like also to point out that Medi-Cal mental health services in California are provided under the Rehabilitation Option which specifically includes that services may be provided under the direction of a Licensed Practitioner of the Healing Arts (LPHA) which as described at Title 9, CCR, Section 1810.223.

The Department is not clear what CMA means by "denial of care". The Department will respond to this question assuming CMA means situations when treatment is denied based on medical necessity determinations. Assessments of beneficiaries to determine medical necessity to receive MHP services may take many forms, not all of which may involve activities requiring licensure. Beneficiaries receive notice of their rights to request a second opinion delivered by a licensed mental health professional of the MHP, file a grievance or appeal with the MHP, and subsequently request a fair hearing, if the MHP determines medical necessity is not met and the beneficiary disagrees with that decision. Once the beneficiary has been determined to meet medical necessity criteria, a thorough assessment is required by the contract between the Department and the MHP, Attachment C. MHP payment authorization decisions are administrative functions, not the practice of a profession.

Comment: CHA- 1 comments that the regulations were not substantively changed in the light of the fact that there is now ten years of implementation of inpatient consolidation. CHA comments that access is a significant issue for inpatient and psychiatric services.

Response: The Department disagrees with this comment. The Department advocates that there have been changes to previous Title 9 draft regulation packages based on previous Departmental and public comment.

Comment: CHA-2 in oral testimony commented that access is a significant issue in this state for inpatient and psychiatric services. We have had over 300 beds close in the last 20 months and we have a significant concern that that trend is going to continue.

Comment: CHA-3 in oral testimony commented that a lot of the decisions by our hospitals to close are predicated upon the difficulties that they are having working with their county mental health plans specific to the contracting requirements. And we have detailed those in our written testimony.

Comment: CHA-4 in oral testimony commented that regional variations have also been identified between Northern California and Southern California in the contracting process. Southern California tends to be a take it or leave it approach by the County's two hospitals, where in Northern California truly there is negotiation and

a dialogue that occurs between these mental health plans and the inpatient hospital facilities.

Response: The Department has received input on hospital issues from several sources. These issues are being addressed in accordance with the Governor's direction in a recent veto of Assembly Bill 467 (2005), in which the Department was directed to conduct a study of hospital rates and prepare a report which will be available after September 2006. The Department is committed to making whatever regulatory changes are found to be necessary to address the issues raised by CMHDA and CHA once a thorough evaluation of the issues has been completed.

Comment: AAMFT-1, CASR-1, the County of Los Angeles, and CMHDA support a change in the regulatory definition describing a Mental Health Rehabilitation Specialist, which is referenced in Title 9, Division 1, Chapter 3, Article 8, Section 630.

Response: The requested change in definition is outside the scope of this regulatory authority of this process.

Comment: Ed Haney-1 comments that as an employee of Los Angeles County, he witnessed patients' rights violations. Mr. Haney relayed his concerns to the Office of Regulations.

Response: This comment is outside the scope of this regulatory process; however, this concern was conveyed to the Department's Office of Human Rights.

Comment: CPA-1 comments that Federal law requires that there must be physician certification of the medical necessity of mental health treatment for recipients of Medi-Cal benefits who receive such treatment and that Federal law also requires that physicians must direct and/or plan most of such treatment and CPA [provides a number of Federal statutes in support of their contention.

Response: The Department disagrees. The regulations do not violate federal law as evidenced by a letter to Daniel Willick representing CPA from Linda Minamoto, Associate Regional Administrator, Division of Medicaid, Health Care Financing Administration, Region IX, dated June 7, 2000, which states: "Our Office of the General Counsel has carefully reviewed the issues you outlined in your letter and has concluded that the Medi-Cal Specialty Mental Health Services proposed regulations do not violate Federal law or regulation." California Business and Professions Code clearly allows for treatment of individuals who are mentally ill by licensed professionals other than physicians

The regulations require MHPs to ensure that persons delivering services do so within their scope of practice, if applicable (Section 1840.314), and that services are delivered by qualified persons in accordance with state law (Sections 1830.444 through1830.358). The regulations also require general compliance with state laws (Section 1810.110(a)). When medical decisions are solely within the scope of practice of a physician, the regulations, therefore, require that the decision be made by a physician. California law, however, permits licensed practitioners of the healing arts to provide a wide range of services within their individual discipline's scope of practice.

Subchapter 1. General Provisions

Article 1. General

Section 1810.110 Applicability of Laws and Regulations and Program Flexibility

1810.110(d)
Comment: PAI-2 comments that under 1810.110 (d). Applicability of Laws and Regulations, "Department" is repeated twice. One of the references to Department should be deleted.

Response: The Department has corrected this typographical error.

Comment: CMA comments that (d) should include a process for public input into the process of waiving requirements.

Response: The Department has reviewed subsection (d) and notes that previous amendments were made to Sections 1820.110, 1820.120, 1830.105, and 1830.115 to clarify that MHPs may obtain approval from the Department to have alternative contracts with providers under Section 1810.438 to explore capitated or related payment mechanisms to explore risk-based contracting arrangements in anticipation of the implementation of Welfare and Institutions Code, Section 5779.

The Department also notes that there is a robust process for public (including consumer) input into decision-making through all levels of mental health administration. This policy has evolved as an overarching philosophy within DMH. The policy that placed in statute at Welfare and Institutions Code Section 14682 (Chapter 33, statutes of 1994), required the Department to convene a steering committee that would include the public as part of the implementation of mental health managed care in California has evolved into multiple stakeholder forums that continue to advise the Department in all areas of the administration of the mental health program. The addition of such a regulatory requirement is unnecessary and it would result in enormous

administrative burden; therefore, the Department does not agree this activity should be placed in regulation.

1810.200 Action

Comment: PAI-3 comments that the definition of action does not follow the federal definition. PAI indicates it believes that the proposed definition is much narrower than the federal definition because the federal regulation does not limit the definition of action to denial or modification of a provider's request for MHP payment authorization. PAI also argues that the federal definition includes a denial of a beneficiary's request for a service in the definition of action.

PAI indicates that the federal definition of reduction, suspension, or termination of a previously authorized service." 42 C.F.R. § 438.400(b)(2) is broader than denial of a provider's request for MHP payment authorization. It includes a situation in which a provider's request for MHP payment authorization has been approved, and the services are being provided, but the MHP decides before the authorization expires that the service should be reduced, suspended, or terminated.

PAI also argues that the proposed regulation does not make sense in referring to "…termination of a provider's request…." A request cannot properly be said to be "terminated." A service, which is being provided on an ongoing basis, can be terminated, but a request cannot be, at least within the meaning of this regulation.

Response: The Department has reviewed both Section 1810.200 and the Federal Regulations at Title 42, Code of Federal Regulations, (CFR), Section 438.400(b)(2) and find that this section of the regulations is sufficient as written to meet the intent of the Federal requirements. The Centers for Medicare and Medicaid Services (CMS) approved the Department's approach to the implementation of Title 42, CFR, Section 400(b)(2) under the most recent waiver approval process. CMS issued a letter of approval on April 26, 2005.

The Department has designed the problem resolution process to ensure that beneficiaries' requests for services that are denied are handled through a simple, and easy to negotiate process. In the event a beneficiary disagrees with a decision regarding a request for a particular service the beneficiary may formalize the disagreement though the request through the beneficiary problem resolution processes described at Section 1850.205, 1850. 206, 1850.207, and 1850.208 which, provides for a grievance and appeals process. Once these processes have been exhausted, if the beneficiary is not satisfied with the outcomes they have the option to file for a state fair hearing as described at Section 1850.213.

1810.202 Administrative Day Services

Comment: NAMI-7 comments that the regulations should incorporate the requirement that MHP's assure that services include the entire spectrum of care, including

*residential care options. NAMI comments that it feels that this section allows MHPs to use Administrative Day Services rather than assuring that it offers all necessary services, including residential placement, and that the section increases financial strain on acute care facilities, who NAMI indicates have no incentive, in view of the scarcity of acute beds, to keep patients longer tha*n is *medically necessary.*

Response: The Department does not have the authority to require MHPs to find non-acute residential treatment facility placements, because the residential component of the residential treatment facilities themselves are not services covered by the MHPs. Although county mental health departments have significant involvement in decisions about placements in some types of facilities, e.g., nursing facilities designated as institutions for mental diseases, this responsibility is independent of a county mental health department's contractual obligations as an MHP. Neither the MHPs nor county mental health departments have authority to make placement decisions in other types of facilities, e.g., foster care group homes, nursing facilities covered by the regular Medi-Cal program, and developmental centers.

1810.203 Adult Residential Treatment

Comment: CPA-4 comments that this section ought to incorporate reference to necessary medication support and/or therapy among the range of services.

Response: The Department has reviewed Section 1810.203 and believes that it is not necessary to incorporate medication support and/or therapy among the range of services available under Adult Residential Treatment. The regulation does not prohibit Medi-Cal beneficiaries from receiving medication support and/or therapy as medically necessary. These services and service activities are defined and claimed differently. Medication support services are defined at Section 1810.225 and reimbursed separate from residential costs as defined at Section 1840.326. Therapy is a service activity provided under the definition of mental health services as defined at Section 1810.227 and is reimbursed as such as defined at Section 1840.316.

1810.204 Assessment

Comment: CHA-2 and CPA-2 comment that the definition fails to address the need for a medical review to rule out a differential diagnosis. CPA-2 suggests the language be changes to include "medical-physical" assessment.

Response: The Department disagrees with the comment and the recommendation. The physical health care needs of Medi-Cal populations are covered benefits of the Medi-Cal program outside the scope of the mental health waiver program. Section 1810.415(b) places requirements upon MHP's to ensure coordination of the beneficiary's physical and mental health care needs. The components of the mental health assessment described in the annual contract at Exhibit 1, Attachment 1, Appendix C between DMH and

MHPs includes language sufficient to ensure relevant physical health conditions reported by the client shall be prominently identified and updated as appropriate.

1810.205.1 Border Community

Comment: David Horner-2, County of Orange, comments that the regulation language is vague and open to interpretations by MHPs because it does not specify communities meeting the definition of "Border Community" interpretations that vary between MHPs. Mr. Horner believes that this may translate into situations in which ongoing consumers may not be able to access providers who have been providing them services, and new consumers may find themselves caught between differing interpretations, also causing problems in access.

Response: The Department disagrees with adopting this comment because MHP's are responsible for out-of-state services only when they are provided in border communities which are defined as the communities outside the State which routinely serve beneficiaries. (See Section 1810.355). The concept of border communities is also important in the rate setting process for psychiatric inpatient hospital services (Section 1820.110). The Department does not possess an exhaustive list of such communities that may routinely serve beneficiaries.

1810.205.2 Client Plan

Comment: CPA-6 comments that language should be inserted to clearly indicate DHHS intent that treatment plans must be prescribed by the treating psychiatrist to clearly indicate DHHS intent through the Integrity Agreement between the Office of the Inspector General and Ventura County.

Response: The Department disagrees with this comment and recommendation. The problems experienced by Ventura County were as a result of violations of federal Medicare laws, which differ significantly from the federal Medicaid laws that apply the Medi-Cal specialty mental health services program governed by these regulations. If Ventura County has agreed via an integrity agreement with the federal government that it will require physician involvement in all Medicaid services, the Department finds nothing in these regulations that would prevent Ventura County from complying with its agreement.

1810.209 Crisis Intervention
1810.210 Crisis Stabilization

Comment: NAMI-8 comments that service activities for these two benefits should include medical review and medication support.

Response: The Department does not agree with the comment and recommendation. This definition provide a specific description of this specialty

mental health service covered by the MHPs and distinguishes among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definitions are based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this chapter. The definition lists service activities, one of which must be a component of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis.

1810.212 Day Rehabilitation and
1810.213 Day Treatment Intensive
*Comment: CPA-7 comments that service activities language should clarify that medication support, management or therapy is included in the defin*ition.

Response: The Department does not agree with this comment and recommendation. The definitions of these services provided specific description of the specialty mental health service covered by the MHPs and distinguishes them from the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definitions of these services are based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this chapter. The list of service activities that are provided are those that are likely to be components of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis.

1810.216 Emergency Psychiatric Condition
Comment: CPA-8 comments that the section should include a reference to and explicitly encompass patients who present in an emergency department and for who it is necessary to provide services under the criteria in this section.

Response: The Department disagrees with this comment and recommendation because this definition is only meant to provide direction to MHPs and providers about what constitutes an emergency under this chapter. Definitions of emergencies commonly used in the health care industry focus on medical, rather than psychiatric conditions and, therefore, would not be applied consistently by MHPs or providers. The definition is based on the definition established in January 1995 in Title 9, Section 1769, for psychiatric inpatient hospital services, but has been modified to cover the additional specialty mental health services covered by this chapter. Beneficiaries presenting in emergency rooms may or may not present with an emergency psychiatric condition.

1810.216.2 Expedited Appeal
1810.216.4 Expedited Fair Hearing

Comment: PAI-4 indicates that the definitions of expedited appeal and expedited fair hearing require that the beneficiary and/or the beneficiary's provider "certify" that an expedited appeal or fair hearing is necessary. PAI suggests that the term "certifies" does not appear on the federal regulations and could be confusing or misleading. PAI suggests that the term can suggest that more than a statement is needed by the beneficiary or the provider to request an expedited appeal or fair hearing. PAI argues that the federal regulation uses the word "indicates" (42 C.F.R. § 438.10). The word "certifies" in the proposed regulation should be replaced with the word "indicates" so that the state regulations will conform with the federal requirements.

PAI suggests that the same change should also be made in section 1850.208(a). The definition of action does not follow the federal definition.

Response: The Department does not agree with this recommendation. The Department, in consultation with CMS, has used the word "certify" in lieu of the word "indicate". Because the Department in consultation with CMS determined that the federal language is nonspecific. The Department believes the term "certify" is less ambiguous the term "indicates" and provides better instruction to MHPs and providers.

1810.218.1 Grievance.

Comment: PAI-5 indicates that the definition states that grievance means the beneficiary's "verbal or written" expression of dissatisfaction and believes that the use of the word "verbal" can lead to confusion because verbal can mean either oral or written. PAI believes that the regulation should state that grievance means the beneficiary's "oral or written" expression of dissatisfaction and that would be consistent with language used in the federal regulations and also with other proposed specialty mental health regulations that use the term "oral." Also, PAI recommends that all of the regulations should be revised so that wherever the regulations read "verbal or written" this is changed to "oral or written."

PAI suggests that the regulation should also define grievance to include denial of expedited resolution of an appeal 42 C.F.R. § 438.406(a)(3)(ii)(B).

Response: The Department believes that the words verbal and oral are interchangeable and the language was selected in consultation with CMS to assure it met federal requirements language and format requirements of 42 CFR, Section 438.10(c) and (d) to ensure ease of understanding.
Further, the Department believes that this regulation as written is broad enough to encompass the intent of 42 CFR 438.406, and it is therefore unnecessary and inappropriate to restate the federal regulation within the state regulation.

1810.218.2 Group Provider

Comment: CACFSR-1 recommends that Group providers include entities such as independent practice associations, hospital outpatient departments, health care service plans, and clinics.

Response: The department disagrees that this distinction is necessary because rate setting and claiming FFP requirements for individual and group providers are different under this chapter from the requirements applicable to organizational providers, consistent with the terms of the State's approved federal waiver. Organizational provider defines entities that have historically participated in the Medi-Cal program as Short-Doyle/Medi-Cal providers on a cost reimbursement or negotiated rate basis involving submission of annual cost reports. These requirements will continue under this chapter (Sections 1830.105 and 1840.105). Individual provider and group provider defines providers that have historically participated in the Medi-Cal program on the basis of fee-for-service rates established by the State with no requirement for annual cost reports and that, under this chapter, are not required to submit cost reports to the Department (Section 1840.105). These providers, absent a contract with the MHP, are paid at the regular fee-for-service Medi-Cal rate applicable to the service provided (Section 1830.105).

This definition does not in and of itself limit the ways in which providers may provide services under this chapter. A single provider may meet the definition of a group provider or the definition of organizational provider depending on the terms of the contract between the MHP and the provider or, absent a contract, on the way in which an individual service was delivered. Providers who deliver services as staff or contractors of an organizational provider are not precluded from also delivering services as an individual or group provider solely based on the definitions in this article. Group providers have been defined separately from individual providers to distinguish group providers more clearly from organizational providers, since group providers include categories that might otherwise be assumed to be organizational providers, such as clinics and hospital outpatient departments.

1810.219 Hospital

Comment: CHA-3 comments that including psychiatric health facilities under the definition of a hospital should only occur if the authority for the definition is cited.

Response: The Department disagrees with this comment. This definition clarifies the types of institutions covered by the regulations in this chapter applicable to hospitals and psychiatric inpatient hospital services. This definition allows the term hospital as used in this chapter to include psychiatric health facilities that have been certified by the Medi-Cal program to provide psychiatric inpatient hospital services. These psychiatric health facilities are not hospitals under definitions typically used in the health care

industry, but the requirements of this chapter applicable to psychiatric inpatient hospital services are intended to apply to them. Their inclusion in the definition allows for a clearer reference in applicable regulations.

1810.220 Hospital Based Ancillary Services

Comment: CHA-4 recommends that the term "history and physical" be included in this definition as an ancillary service.

Response: The Department does not agree that the terms " history and physical" should be included in the definition. This section establishes a definition of what is included in psychiatric inpatient hospital services rates that is applicable statewide. Psychiatric inpatient hospital services rates negotiated by MHPs under these regulations may be applicable to other MHPs using the same hospital. Negotiated rates also form the basis of the rates established by the Department for non-contract hospitals. The ancillary services included have a substantial impact on total cost of hospitalization and must be consistent statewide. Two services included under hospital-based ancillary services, electroconvulsive therapy (ECT) and magnetic resonance imaging (MRI), have been specifically included in the definition because they may represent a significant cost factor and may not be universally understood to be included. Prescription drugs have been specifically included to clarify that these drugs are covered by the MHP as part of psychiatric inpatient hospital services, even though they are excluded when they are provided as a separate service (Section 1810.355). Medical histories and physicals are routine services included in the rate as described.

1810.221 Individual Provider

Comment: CACFSR-2 comments that the regulation should be clear that contractors can be and act as individual providers at times when they are not actively working for an organizational provider. CACFRS proposes to change the term "when" to the phrase "at the time that" in the definition of Individual Provider.

Response: The Department does not believe a change in the definition is necessary.
This regulation distinguishes among individual, group and organizational providers. The distinction is necessary because rate setting and claiming FFP requirements for individual and group providers are different from the requirements applicable to organizational providers, consistent with the terms of the State's approved federal waiver. Organizational provider defines entities that have historically participated in the Medi-Cal program as Short-Doyle/Medi-Cal providers on a cost reimbursement or negotiated rate basis involving submission of annual cost reports. These requirements will continue under Sections 1830.105 and 1840.105. Individual provider and group provider define providers that have historically participated in the Medi-Cal program on the basis of fee-for-service rates established by the State with no requirement

for annual cost reports and that, under this chapter, are not required to submit cost reports to the Department (Section 1840.105). These providers, absent a contract with the MHP, will be paid at the regular fee-for-service Medi-Cal rate applicable to the service provided (Section 1830.105).

This definition as written does not in and of itself limit the ways in which providers may provide services under this chapter. A single provider may meet the definition of a group provider or the definition of organizational provider depending on the terms of the contract between the MHP and the provider or, absent a contract, on the way in which an individual service was delivered. Providers who deliver services as staff or contractors of an organizational provider are not precluded from also delivering services as an individual provider.

1810.222 Licensed Mental Health Professional

Comment: CMHDA-2-a comments that since it appears that "Licensed Practitioners of the Healing Arts" are essentially the same as "Licensed Mental Health Professionals," it would seem to make sense that this Section should make reference to the fact that they can be interchangeable for this program. This could eliminate confusion at the local level.

CMHDA-2-b also supports the request by the California Association of Social Rehabilitation Agencies (CASRA) to change the regulatory definition describing a Mental Health Rehabilitation Specialist (MHRS) as found in Title 9, Division 1, Chapter 3, Article 8, Section 630. We agree that a more expansive definition that includes a designation of those who are Certified Psychiatric Rehabilitation Practitioners (CPRPs) is a major step toward meeting the current need for recovery-oriented mental health workers, both in terms of numbers and skills. If the Department agrees to make this change, it would make sense to specifically include the CPRFs in these regulations wherever Mental Health Rehabilitation Specialists are referenced.

Response: The definition is necessary to provide a single term for use in this chapter to establish authorization and staffing standards when licensed personnel are required, rather than listing individual types of practitioners separately. The Department believes continuing to employ a single term that is already recognized is preferable then to introduce new terms to this regulatory package.

As previously stated under General Comments in response to the comment submitted by CASRA to change the regulatory definition describing a Mental Health Rehabilitation Specialist (MHRS) as found in Title 9, Division 1, Chapter 3, Article 8, Section 630, such a change is outside the scope of this regulatory action.

Comment: CHA-5 and CPA-9 recommend that physician assistants and nurse practitioners should be added to this definition for clarification purposes.

Response: This change would necessitate modification of the State Plan and approval by CMS. Such a modification is not practical at the present time.

1810.225 Medication Support Services
Comment: CACFSR-3 comments that medication education be identified in the list of Medication Support Services Activities.

Response: This definition provides a specific description of the specialty mental health services covered by the MHPs and distinguishes among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this chapter. The service activities listed are those that are likely to be components of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis. "Education" of this sort may or may not be a Medi-Cal covered benefit; thus, including it in this definition could be misleading.

1810.227 Mental Health Services
Comment: CACFSR-4 comments that it recommends clarification that mental health services are those that meet the definition as stated and not provided to the beneficiary as part of other services.

Response: The Department does not completely understand this comment as written. The Department has reviewed the definition of mental health services and is satisfied that the text is clear as drafted, and does not support the need for a change.

1810.231 Organizational Provider
Comment: CMA and CPA comment that the word "not" may have been included in error.

Response: The Department agrees and has corrected this typographical error.

1810.231.1 Physical Health Care or Physical Health Care Based Treatment
Comment: CMA-16 and CPA-11 comment that the word "not" may have been included in error.

Response: This definition is correct as written. This definition provides a term to describe health care, other than specialty mental health care, so that that

clear distinctions may be made between services covered by MHP and not covered by MHPs.

Comment: CPA -11 comments that psychiatrists are physicians, do deliver medical care and are preferred due to many factors, including metabolic syndrome.

Response: Section 1810.231(a) specifically recognizes psychiatrists as physicians.

1810.233 Point of Authorization

Comment: NAMI-9 comments that it believes that all provisions addressing authorizations and denials of mental health services must be carefully reviewed and MHP obligations strengthened. MHP's must be required to assign this function to an individual who, by training and experience, understands and can appropriately assess the required medical determination.

Response: The Department disagrees that specific regulatory obligations should be included in definitions. The Department believes that the appropriate place to deal with the MHPs' authority to delegate their obligations is in the contract between the MHP and the Department, and has done so. The applicable provision is included in Article V, Section S of the boilerplate contract. The proposed regulations address the issue only when there are limits to the delegation authority that must be addressed on a statewide basis.

Comment: CHA-6 comments that the definition allows for too much subjectivity, that current practice has provided evidence that denials by laypersons are often inappropriate, and that assignment for denial authority be given only to physicians.

Response: The Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

Comment: CMA-3, CHA-6, and CPA-12 comment that all denials for care be reviewed and be under the responsibility of a physician. CMA further recommends that the function be under the purview of a plan medical director.

Response: The Department disagrees with the comment. The regulations require MHPs to ensure that persons delivering services do so within their scope of practice, if applicable (Section 1840.314), and that services are delivered by qualified persons in accordance with state law. The regulations also require general compliance with state laws (Section 1810.110(a)). When

medical decisions are solely within the scope of practice of a physician, the regulations, therefore, require that the decision be made by a physician. California law, however, permits licensed practitioners of the healing arts to provide a wide range of services within their individual discipline's scope of practice. As indicated above, the Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

1810.240 Psychiatrist Services

Comment: CPA-13 comments that board certification or eligibility for board certification in psychiatry is a quality indicator that ought to be considered as a necessary condition for the contracting of psychiatric services.

Response: This regulation establishes a term that can separately identify specialty mental health services provided by individual or group providers who are physicians. Separately identifying this type of service in terms of the physician's psychiatric specialty or certifications as self identified to the Medi-Cal program provides a basis for MHPs to identify whether a service provided by a non-contract physician in an emergency is a specialty mental health service covered by the MHP or an excluded service. Section 1810.435 addresses provider selection criteria, and relates these criteria to quality generally. The Department does not agree that such language is appropriate to add to a definition.

1810.246 Small County

Comment: CPA-14 comments that the reference should be to 2000 census, rather than 1990.

Response: The methodology used to establish "small counties" relies upon 1990 census data, and will not be changed in this regulatory action. Statute at Welfare and Institutions Code, Section 5778(j) sets the population of a small county at 200,000, but does not identify the database that will establish the number. The Department established 1990 census data as the source because it is widely accepted and available.

1810.249 Targeted Case Management

Comment: CHA-7, NAMI-10 and CPA-15 comment that transportation and housing be included in the service descriptions.

Response: Although the list of service activities provided under Targeted Case Management is not meant to be exhaustive. Targeted case management is

intended, as stated in the regulation, to assist beneficiaries to access any needed medical, educational, social, prevocational, rehabilitative, or other community services. Neither "transportation" nor "housing" are exclusively Medi-Cal covered benefits and therefore including such terminology could be subject to misinterpretation.

1810.250 Therapy

Comment: CMA-17 and CPA-16 recommend that this section should be amended to state that therapy includes medication support services.

Response: This citation defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication which might otherwise be required in the individual service definitions such as "medication support services " at Section 1810.225 is not inclusive of therapy. Mental health services and medication support services are separately reimbursable and distinct Medi-Cal services.

1810.254 Waivered/Registered Professional

*Comment: NAMI-11 comments that the authorities cited for the provision (Section 5777, 14680 and 14684 of the Welfare and Institutions Code) do not address or provide underlying authority for the definition. NAMI recommends that the section be modified to incorporate circumstances under which a waiver of psychologist licensure or the use of other professional*s can occur.

Response: This issue is outside of the regulatory authority of the Department of Mental Health, and the reference is to the Department's broad authority to administer its mental health programs. The term "waivered/registered" refers to categories described in Section 5157.2 of the Welfare and Institutions Code.

1810.305 Designation of MHPs

1810.305(a)(1)

Comment: CMA-12 comments that it appears that the regulations require that a provider must be enrolled as a Medi-Cal provider in order to contract with an MHP. CMA urges that MHPs be allowed to contract with qualified providers who are willing to serve the already underserved population. CMA and CPA recommend that subsection (a)(1) be amended to require that an MHP assure access to services to be better than access provided to beneficiaries prior to operation of the MHP.

Response: Federal regulations require a provider of Medicaid services to be enrolled as a Medi-Cal provider. The intent of the requirement is to ensure certain standards of good programmatic and administrative practice. Under the Federal 1915(b) Waiver approval by CMS, MHP's retain the authority and

responsibility to assure sufficient capacity to meet the needs of the Medi-Cal population. MHP's can select providers to best manage service delivery in their own communities. To ensure access, Title 9 regulations go beyond federal requirements.

Comment: Under Subsection (a)(1) CMA-13 recommends that this section be amended to require that a MHP assure access to services be better than access provided to beneficiaries prior to operation of the waiver by not limiting beneficiaries' choice of providers.

Response: DMH is unclear of the intent of the comment because the language included in Section 1810.305 does states: "The county is willing to assume responsibility for Medi-Cal authorization and payment for all covered specialty mental health services for beneficiaries of that MHP and assures that access to services through the MHP will be no less than access provided to beneficiaries prior to operation of the MHP." The Department believes this language is specific enough to satisfy the comment.

Comment: CPA-17 comments that standards for access be developed so that a benchmark is used statewide for such determinations and that the development of such standards be in conjunction with a statewide stakeholder input from all interested parties.

Response: The Department includes public input at all levels of program administration as described in the response above to comment by PAI-2 regarding Section 1810.110.

1810.310. Implementation Plan

Comment: PAI-6 indicates that 1810.310(c)(2) requires an MHP to notify the state of a change in its approved implementation plan only if the change in the MHP's operation would require changes in services or providers by 25% or more of the beneficiaries who are receiving services from the MHP or a reduction of an average of 25% or more in provider rates for providers about patient mental health services than paid on a fee for service basis. PAI asserts that federal regulations require notice of a significant change, 42 C.F.R. 438.207(c)(2), and that the 25% standard constitutes inadequate oversight by the state. PAI asserts that MHP's should report changes of 5% or more and should justify the facts related to the change.

Response: Title 42 CFR, requires in Section 438.207 (c) regarding the timing of documentation that each MHP (referred to as a Prepaid Inpatient Health Plan or PIHP) must submit the documentation described in paragraph (b) of that section as specified by the State, but no less frequently than at the time it enters into a contract with the at any time there has been a significant change as defined by the State in the MHP's operations that would affect adequate capacity and services, including at any time there has been a significant

change as defined by the State in the MHP's operations that would affect adequate capacity and services. The Department considers it administratively burdensome to impose a 5% change standard upon mental health plans. A 25% standard approved by CMS is reasonable and is administratively feasible in terms of the plans' ability to measure changes in the network.

1810.345 Scope of Covered Specialty Mental Health Services

Comment: PAI-7 comments that this regulation suggests that MHPs need only provide medically necessary services that are within the scope of the services the MHP chooses to provide, rather than within the scope of all specialty mental health services that the MHP is required to provide under the Medi-Cal program and that this is a violation of federal law. 42 C.F.R. § 438.210(a)(1) and (2). PAI further comments that it believes that the regulations should state that the county must provide all medically necessary services within the scope of the services authorized under the regulations.

Response: This Section does not violate federal law at Title 42 CFR, Section 438.210(a)(1) and (2) regarding the coverage and authorization of services. This Section requires the State through it's contracts with MHPs to identify, define, and specify the amount, duration, and scope of each service that the MHP is required to offer and require that the services identified in paragraph (a)(1) of the section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in Title 42, CFR Section 440.230. Section 1810.345 clarifies the plans' responsibility consistent with the requirements of Title 42. This responsibility is further established in the MHP contracts.

Comment: CACSF-5 comments that the section should not limit EPSDT services.

Response: The Department does not agree that the section limits EPSDT services or needs to be rewritten. EPSDT is addressed in Section 1830.210 and is consistent with the requirements for the provision of services under EPSDT in United States Code (USC), Section 1396d(r) and Title 22, CCR, Section 51184.

1810.355 Excluded Services

1810.355(a)

Comment: CHA-8 comments that all patients admitted for inpatient psychiatric care are required to have a medical history and physical within 24 hours of admission, per Title 22 and it is therefore inconsistent to exclude payment from a primary care physician. CPA-18 comments that the section is not clear about payment for medical services that may not be covered by Medicare or Medi-Cal managed care.

Response: The Department does not agree with the comment. The Department has developed a program, consistent with state law that focuses on specialty mental health services. Professional services to treat physical health care conditions or to rule out such conditions, as in the history and physical required as a part of admission for psychiatric inpatient hospital service, should not be the responsibility of the MHPs. Coordination is an important issue, however, and has been addressed in Section 1810.370, which requires memorandums of understanding between Medi-Cal managed care plans and MHPs. DHS has recently provided clarification to Medi-Cal managed care plans on coordination of services between Medi-Cal managed care plans and MHPs in MMCD Policy Letter 00-01 REV, dated March 16, 2000 REV and titled "Medi-Cal Managed Care Plan Responsibilities Under the Medi-Cal Specialty Mental Health Services Consolidation Program."

Comment: CPA-18 requests clarification about responsibility for the payment of medical transportation services required for beneficiary who is being transported from an emergency department to an appropriate psychiatric inpatient facility.

Response: Although the Medi-Cal program as a whole must meet federal Medicaid requirements on transportation to services, there is no obligation for the Medi-Cal program to include this obligation in its managed care contracts. Neither the responsibility for medical transportation as provided by the Medi-Cal program in Title 22, CCR, Section 51323, nor the Medi-Cal program's responsibility for transportation as an administrative expense have been transferred to the MHPs. Transportation to mental health services remains available to beneficiaries in the same way it was available to them prior to the implementation of the Medi-Cal specialty mental health services program.

1810.355(b)

Comment: PAI-8 comments that Section 1810.355(b) suggests that until a beneficiary has exhausted Medicare benefits, the beneficiary is entitled to no specialty mental health services under the Medi-Cal program. PAI asserts beneficiaries are eligible for services under the Medi-Cal program to the extent that those services are not covered under Medicare, whether or not the individual has also exhausted Medicare coverage and cites case management and residential treatment services as examples. PAI also asserts that Medicare services that are not available under the adequate capacity standards for specialty mental health services do not have to be accessed because they cannot be. PAI additionally suggests that beneficiaries should not be required to exhaust Medicare benefits if the nearest Medicare provider is one hour away, when the MHP capacity standard for Medi-Cal providers requires that the provider be no more than one-half hour away. PAI recommends that the regulation should be amended to provide exclusion and exception to the exclusion:

Response: The Department is unclear how the citation at Section 1810.355(b) is related to Medicare reimbursements. This Section addresses situations in which MHPs are not responsible to provide or arrange and pay for out-of-state specialty mental health services except when it is customary practice for a California beneficiary to receive medical services in a border community outside the State. The Department does not agree to the recommendations made by PAI because they are not relevant to this provision.

1810.355(d)

Comment: CMA-18 comments that: 1) this section lacks clarity because physicians have no way of knowing that Medicare services have been exhausted. 2) CMA also believes the physician should be held harmless for providing services to a patient who needs care and that the MHP should be required to work with Medicare. 3) CMA also indicates that it is not clear when administrative day services are covered and when not.

Response: The Department has reviewed the provisions of Section 1810.355(d) and considers this Section to be clear about that MHPs are not responsible to provide or arrange and pay for specialty mental health services when they are provided to a beneficiary eligible for Medicare prior to the exhaustion of beneficiary's Medicare mental health benefits, unless the services have been denied by Medicare. Administrative day services are excluded only if the beneficiary is in a hospital reimbursed through Medicare (Part A) based on Diagnostic Related Groups (DRGs), when the DRG reimbursement covers administrative day services according to Medicare (Part A). The Department disagrees with the comment.

1810.355(g)(3)

Comment: PAI-8 recommends that Section 1810.355(g)(3) should be amended to specify that the listed services are provided pursuant to Title 22. PAI asserts that "this is the intent of the regulation, but it is unclear from the text of the regulation whether the services listed are Medi-Cal services, or services funded under the CCS or GHPP programs."

Response: The Department does not have regulatory authority to define services included in Title 22 regulations. The Department does not have the authority to establish regulations through the Medi-Cal program, except to regulate services provided by MHPs. The concern with Section 1810.355(g)(3) should therefore, be addressed to DHS.

1810.360 Notification of Beneficiaries

Comment: PAI-9 comments that Section 1810.360(a)(3) provides that beneficiaries will be notified of the availability of a booklet that contains the information required by "22 C.F.R. § 438.10(f)(6) and (g)" (sic), but disagrees with the way the regulation is

drafted in that (PAI) believes that the booklet should contain boilerplate information specified by the Department.

Response: The Department has implemented information requirements as provided for in 42 CFR 438.10(f)(6) and (g) which is consistent with the requirements in 42 C.F.R. § 438.10(f)(6) and (g)" (sic) and is in the process of distributing the information in accordance with a timeline approved by CMS. These requirements are also reinforced through contract language between the Department and MHP's. 42 CFR 438.10(f)(6) and (g) does not require the State to implement or require boilerplate language. In the absence of a regulatory obligation, the Department does not agree that requiring MHPs to use boilerplate information is practical or reasonable. Section 1810.360 addresses the general content of the brochure and provides necessary flexibility to the MHPs to match the brochure to the specific organization of the MHP.

Comment: NAMI-2 (refers to 1810.50 however it appears this is a typographical error, the correct citation is 1810.360) comments that the section should be revised to require plans to provide beneficiaries with timely information as to changes, additions, or deletions in the providers being used to provide care. NAMI suggests that the information could also be placed on a website.

Response: The Department disagrees with the comment. The Department requires MHPs to provide beneficiaries with timely information as previously described, (please refer to the response by the Department to comments on Section 1810.310) and does not consider requiring the use of the Internet as a medium for conveying information to be a reasonable use of resources.

Comment: CPA-19 comments that the department should examine and to the extent necessary determine to what extent it can streamline and make efficiencies so clinical resources are not be diverted for notification requirement purposes.

Response: The Department thanks CPA for its comments.

1810.365 Beneficiary Billing

Comments: CHA-9 comments that Subdivision (a) prohibits an MHP from charging beneficiaries for copies of client records which is in conflict with both state and federal law.

Response: The Department disagrees. Section 1810.365 prohibits the MHP and its providers from billing beneficiaries except in specific situations. This regulation clarifies that an MHP and its providers are customarily not allowed to bill beneficiaries for specialty mental health services or other related administrative services, such as billing for missed appointments or for transferring medical records to a new provider.

Comment: CPA-20 comments that billing beneficiaries should be confined to persons with legal capacity and competence.

Response: The Department believes that a change in regulations based on these issues is outside the scope of this regulatory action. Capacity and competence are clinical and legal determinations that must be dealt with on an individualized basis and do not lend themselves to the scope of this citation.

1810.370 MOUs with Medi-Cal Managed Care Plans

1810.370 (a)(1)
Comment: CHA-10 comments that this subsection should be stronger in requiring MHP's to determine who will be responsible for payment of services before the beneficiary is referred.

Response: The Department disagrees because this suggestion could lead to delays in timely access to medically necessary treatment.

1810.375(a)(5)
Comment: CHA-10-a comments that it is important to have a process to pay providers during any dispute and it recommends language to provide for such payment.

Response: The Department does not agree that the MOU dispute resolution process should include a means to pay providers while the dispute is being resolved. Issues regarding payment arrangements between the MHP and its providers and the MCP and its providers should be addressed in the contract between the provider and the plan, not in an MOU intended to address the relationship between the MHP and the MCP.

1810.370 (b)
Comment: CHA10-b urges that this subsection be amended to ensure someone is held responsible for payment of services provided under the MOU.

Response: Please see the response to CHA-10.

Comment: CPA-21 comments that this section should establish protocol and payment responsibility for appropriate and necessary transportation costs and should include language so that MOUs specify joint responsibilities.

Response: Although the Medi-Cal program as a whole must meet federal Medicaid requirements on transportation to services, there is no obligation for the Medi-Cal program to include this obligation in the MOUs. Neither the responsibility for medical transportation as provided by the Medi-Cal program in Title 22, CCR, Section 51323, nor the Medi-Cal program's responsibility for

transportation as an administrative expense have been transferred to the MHPs. Transportation to mental health services remains available to beneficiaries in the same way it was available to them prior to the implementation of the Medi-Cal specialty mental health services program. A clarifying provision exists in Section 1810.100 explaining that services not covered by the MHP are available through the regular Medi-Cal program.

1810.375 MHP Reporting

Comment: CHA-11 and CPA-22 comment that the data reporting requirements are inadequate for monitoring access and encourage a provider as well as beneficiary grievance process as a matter of fairness. CHA recommends the addition of several reporting elements.

Response: The Department does not agree that the additional MHP reporting requirements suggested by CHA are appropriate. The regulations are intended to balance the need for data at the State level on plan operation and the need to be reasonable about the administrative costs of the program. The data CHA suggests for inclusion is available to the Department at the MHP level. The Department's oversight of MHPs, as described in Section 1810.380, will be a combination of data analysis based on utilization data which is submitted to the Department as part of the process of claiming FFP on a fee-for-service basis, analysis of the reports required by this section, on site visits by contract management staff, follow up on beneficiary complaints, and formal on site compliance reviews.

1810.380 State Oversight

Comment: NAMI-3 and CMA-19 both comment that they believe subsection (a) should be expanded to assure that an MHP has a sufficient number of providers for the guaranteed service and access requirements.

Response: The Department disagrees with this comment because access standards are already addressed in Section 1810.310 (5) (A). This Section requires MHPs to submit to the Department documentation that demonstrates that plans offer an appropriate range of specialty mental health services adequate for the anticipated number of beneficiaries that will be serviced by the plan, and that they maintain a network of providers sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries.

1810.380 (a)(6)

Comment: CHA-12 comments that history has proven that this requires more specificity if the information is to be useful, and recommends that denial trends be monitored specific to mid-stay and last-day denials and charting omission denials.

Response: The comment does not offer a complete explanation of the usefulness of collecting this type of information in the manner described. The Department does not see the relevance of collecting information of this type to this regulatory process.

Comment: CMA-20 requests that 1810.380(e) should be rewritten to provide that treating providers be included in the list of who the Department should consult with when developing a comprehensive oversight program.

Response: AB 757 (W&I Code, Sections 5775 et seq., and 14680 et seq.) establishes a relationship that must be based on federal and state laws and regulations governing the Medi-Cal program and, therefore, creates strong oversight authority and responsibility for the Department, as delegated by DHS, the State's single state Medicaid agency. The Department may not delegate this authority and responsibility to others. The Department, as a public agency, is prepared to and does accept written and verbal complaints and reports directly from the public.

In addition, the department, is required through Welfare and Institutions Code (W&I) Section 5614 to provide for a Compliance Advisory Committee that shall have representatives from relevant stakeholders, including, but not limited to, local mental health departments, local mental health boards and commissions, private and community-based providers, consumers and family members of consumers, and advocates, to establish a protocol for ensuring that local mental health departments meet statutory and regulatory requirements for the provision of publicly funded community mental health services. These activities provide opportunities for treating providers to provide consultation to the Department's comprehensive oversight process.

1810.385 Civil Penalties

Comment: CHA-13 comments that in order to encourage compliance with applicable laws and regulations, the maximum penalties for failure to comply must be meaningful, especially where non-compliance is less costly than potential penalties may be. CHA comments that MHP's should be subject to Knox Keene Requirements.

Response: The Department disagrees that the fines contained in this section should be modeled on the fines levied against Health Care Service Plans (HCSPs). In addition to the example cited by CHA, the Knox-Keene Act provides for civil penalties against anyone who violates the act or related regulations and orders not to exceed $2,500 and for a fine of not more than $10,000 or a prison or jail term of not more than one year if the person is convicted of willful violation of the act or related regulations and orders. DOC (or Department of Managed Care, once recent state law is fully implemented) regulations governing HCSPs, at Title 10, CCR, Sections 1300.43 through

1300.826, do not establish guidelines for determining the specific fine to be levied for any specific violation, so civil penalties may be any amount less than the maximum allowed in statute. DOC's authority to levy up to $250,000 in penalties must also be seen in relationship to the financial position of the largest commercial HCSPs.

The Department's statutory authority for the program does not provide for criminal action against MHPs, nor does it provide any specific standards for the amount of civil penalties. Absent specific statutory authority, the Department believes it is more appropriate to model its fine schedule on the fine schedule established by DHS for its MCPs (Title 22, CCR, Sections 53350 and 53872), taking into account the more limited scope of services and funding for the MHPs.

1810.405 Access Standards for Specialty Mental Health Services

1810.405(a)

Comment: PAI-10 believes Section 1810.405(a) should be rewritten to require that, the MHP provide for a second opinion by a qualified licensed mental health professional that has appropriate clinical expertise in providing specialty mental health services needed to treat the beneficiary's condition, other than a psychiatric technician or a licensed vocational nurse. PAI also believes that the change is supported by 42 C.F.R. § 438.206(b)(3). PAI also believes that federal law requires that denial of services must be made by a professional who "has appropriate clinical expertise in treating the enrollee's condition or disease as supported by 42 C.F.R. § 438.210(b)(3).

Response: The regulations do not violate federal law as evidenced by a letter to Daniel Willick representing CPA from Linda Minamoto, Associate Regional Administrator, Division of Medicaid, Health Care Financing Administration, Region IX, dated June 7, 2000, which states: "Our Office of the General Counsel has carefully reviewed the issues you outlined in your letter and has concluded that the Medi-Cal Specialty Mental Health Services proposed regulations do not violate Federal law or regulation." California Business and Professions Code clearly allows for treatment of individuals who are mentally ill by licensed professionals other than physicians. Section 1840.314 requires MHPs to ensure that services are provided within scope of practice of the licensed professional delivering care. This section further provides that all services be provided under the direction or supervision of a licensed professional.

Comment: CMA-23, CHA-14 and CPA-23 expressed comments that requests for care authorization should be reviewed by an appropriate licensed mental health provider and in the case of a medical necessity determination, that review be made by a licensed physician.

Response: The Department disagrees with the comment. The regulations require MHPs to ensure that persons delivering services do so within their scope of practice, if applicable as described at Section 1840.314, and that services are delivered by qualified persons in accordance with state law as described at Sections 1830.444 through1830.358. The regulations also require general compliance with state laws as described at Section 1810.110(a)). When medical decisions are solely within the scope of practice of a physician, the regulations, therefore, require that the decision be made by a physician. California law permits licensed practitioners of the healing arts to provide a wide range of services within their individual discipline's scope of practice.

Assessments of beneficiaries to determine medical necessity to receive MHP services may take many forms, not all of which may involve activities requiring licensure. Beneficiaries receive notice of their rights to request a second opinion delivered by a licensed mental health professional of the MHP, file a grievance with the MHP, or request a fair hearing, if the MHP determines medical necessity is not met. Once the beneficiary has been determined to meet medical necessity criteria, a thorough assessment is required by the contract between the Department and the MHP, Attachment C. MHP payment authorization decisions are administrative functions, not the practice of a profession.

The Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician, but provides that other qualified staff may approve these requests. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

Comment: CACFS-6 recommends that the variety of private nonprofit providers be listed in the list of appropriate referral sources.

Response: This matter is not within the Department's resources or authority. These lists are maintained by community-based organizations outside of the Department's authority, including the United Way.

Comment: CPA-23-c comments that system procedures include families as a part of the system response and that reasonable consideration of psychiatric history as communicated by families be represented in the regulations.

Response: The Department disagrees. The existing system does not exclude input from families of children and, as appropriate, for adults as part of their services.

1810.405(b)
Comment: CMA-21 comments that "Other mental health providers" should be added to the list of those who can refer a patient to the MHP.

Response: The text of this provision states: "Referrals to the MHP for Specialty Mental Health Services may be received through beneficiary self-referral or through referral by another person or organization, including but not limited to…" The text as written does not exclude other mental health providers and the Department disagrees that a change in text is necessary.

1810.405(c) and (d)
Comment: NAMI- 4 comments that unless the MHP has a toll-free line staffed 24-hours a day, 7 days a week, the requirement is of limited usefulness. NAMI also recommends that subsection (c) be modified to require that the phone lines of obtaining authorization must be staffed by personnel with appropriate training and experience.

Response: The Department does not agree that this requirement is without substance. If the MHP requires that a provider obtain approval of an MHP payment authorization request prior to the delivery of a specialty mental health service to treat a beneficiary's urgent condition as a condition of payment to the provider, the MHP is required to have a statewide, toll-free telephone number available 24 hours a day, seven days per week with the capacity to act on MHP payment authorization requests within one hour of the request.

Additionally, each MHP is required to provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county, that will provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met and services needed to treat a beneficiary's urgent condition, and how to use the beneficiary problem resolution and fair hearing processes.

The Department conducts oversight reviews of these activities to ensure compliance with the requirement. Requiring these toll free lines to be manned by live staff full time creates a needless burden for MHPs and would redirect resources from the direct care of beneficiaries.

Comment: CMA-22 comments that "trained mental health providers" should staff the toll free telephone number 24/7.

Response: Please see the response above to the comment by NAMI regarding Section 1810.405(c) and (d).

1810.405(e)
Comment: CHA-14-b comments that beneficiaries should be informed of their option for a second encounter to be conducted face to face with a licensed mental health professional.

Response: The Department disagrees this change in regulation is necessary. Beneficiaries are informed of their right to a second opinion through the MHP brochures which are provided when a beneficiary first access services and upon request as provided for under Section 1810.360. These brochures are also being mailed to all Medi-Cal households, in accordance with 42, CFR 438.420. Section 1810.405(e). MHPs are required to provide for second opinions if it is determined that the beneficiary does not meet medical necessity for any MHP service based on four specific regulatory cites [Sections 1830.205(b)(1), 1830.205(b)(2), 1830.205(b)(3)(C), or 1830.210(a)]. These are the same regulatory cites included in Section 1850.210(i), which requires the MHPs to send notices of action that include information about the beneficiary's right to request a second opinion. The notice of action forms include information on how to request the second opinion. The contract between the MHP and the Department requires the MHP's quality improvement program to address monitoring of these issues (Appendix A).

1810.410 Cultural and Linguistic Requirements
*Comment: PAI-11 comments that 1810.410(e)(2) implies that the MHPs are required to have interpretation services available only in threshold languages. PAI comments that it feels that 42 CFR 438.10©(4) requires oral interpretation services must be in the prim*ary language of the beneficiary.

Response: The Department disagrees with the comment. The regulations at Section 1810.410 (b)(3) require plans to have in place policies and procedures to assist clients to access services in their primary language which is consistent with the requirements of CFR 438.10(c) (4).

*Comment: CMA-23 comments that it should be made clear that requirements for cultural and linguistic falls with the MHP and is not to be delegated to individual providers. CMA suggests that a mechanism be in place to facilitate the providers obtaining the language serv*ices necessary to treat patients.

Response: The Department is unclear what is meant by the first part of the question regarding cultural and linguistic responsibilities. MHPs are responsible for assuring their subcontractors operate consistently with all laws, regulations and contractual obligations of the MHP under their contracts with the Department. The Department does not agree that the regulation needs to be rewritten to provide this clarification which is already described in the DMH/MHP contract in Exhibit E, Section 7, Item D.c.

1810.415 Coordination of Physical and Mental Health Care

1810.415(a)
Comment: CMA-24 comments that this is very confusing regarding whether another health care provider means a physical care provider.

Response; This provision establishes the MHP's obligation to provide training and consultation to beneficiaries' primary care physicians and other health care providers, including physical care providers.

1810.415(c)
Comment: PAI-12 comments that Section 1810.415(c) should require coordination with Medicare Part D plans, as appropriate, to assist beneficiaries to receive prescription drugs. Otherwise, beneficiaries who are enrolled in Medicare Part D plans may not have access to the drugs that are prescribed by MHP providers.

The reference in section 1810.415(d)(2)(D) to section 1850.210(i) should be to section 1850.210(g). Alison please double check this one thanks

Response: The Department does not agree that Section 1810.415 (c) requires revision to ensure coordination with Medicare Part D plans. The Department has determined that the requirement in subsection (c) that the MHP coordinate pharmacy and laboratory services with pharmacies and MCPs is sufficient from the perspective of regulatory standards for assurance that Medicare Part D coordination will be accomplished.

1810.415(d)
Comment: CHA-15 recommends that the section be rewritten to ensure that the MHP is responsible to facilitate a referral since it is implied that the plans have responsibility to ensure beneficiary physical healthcare needs are met.

Response: The regulation requires the MHP to refer a beneficiary to appropriate physical health based treatment if the beneficiary does not meet medical necessity criteria based on diagnosis, but does require treatment, or if the beneficiary's condition would be amenable to physical health care based treatment. The subsection further clarifies that the MHP is not responsible for making sure the beneficiary actually finds a provider or receives the services to which the beneficiary is referred. This limit is set because without it MHPs would be considered ultimately responsible for all care for beneficiaries, rather than the scope of covered services intended in this chapter. The responsibility to assure appropriate access to care not covered by MHPs rests with the Medi-Cal program as a whole. The Department believes this regulation is sufficient in detail to allow MHP's, when appropriate, and/or possible to facilitate a referral.

Comment: CMA-25 comments that there needs to be assurance that providers will be held harmless when the patient is caught between the MHP and the physical health plan, and that the regulations should require that the MHP be responsible for ensuring and facilitating referrals as needed to ensure medically necessary care.

Response: It is not clear what CMA intends for the Department to act on by this comment. The issue of whether or not the provider is "held harmless" is outside this regulatory action.

1810.430 Contracting for Psychiatric Inpatient Hospital Service Availability

Comment: CHA-16 -a recommends that subsection (c) (1) be amended to require that requests for exemptions require significant justification.

Response: The regulation as written includes reasonable assurances, and the Department believes it is sufficient as drafted.

Comment: CHA -16-b recommends that in subsection (c)(1)(B) the term accessible geographic area be defined for clarity purposes.

Response: The Department disagrees this term should be defined in regulation because it is established by a different State Department and subject to change at that Departments discretion. This data is defined and available on OHSPD's web site at http://www.oshpd.ca.gov/oshpdKEY/finddata.htm.

Comment: CHA -16-c recommends that in subsection (c)(2) the notice be in writing with a copy of the materials sent forwarded to the hospital.

Response: The Department is already obligated to notify both the hospital and the MHP in writing of a final decision as described at Section 1810.430(c) (3). This change would add unnecessary administrative burden to the Department.

1810.435 MHP, Individual, Group and Organizational Selection Criteria

Comment: CHA-17 indicates that hospitals have significant issues with the excessive flexibility in this section of the regulation and references subsection (b)(6) that allows MHPs to request from individuals evidence of auto insurance and drivers licenses as part of their credentialing process.

Response: CHA does not ask for or make a recommendation for a specific change to this regulation. The Department has reviewed Section 1810.435 and has determined this section is not excessively flexible.

Comment: CPA-25-a comments that the selection criterion is not clear that it would require providers to be board certified or board eligible psychiatrists.

Response: This section prescribes requirements for providers. These are all pre-existing conditions specified in either AB 757, Medi-Cal program regulations, the federal waiver, or other state or federal law. The Department disagrees that regulations should contain this level of specificity.

Comment: CPA 25-d states clarification is needed to specify that individuals who deliver psychiatric medical care should possess the necessary license or certificate to practice medicine independently.

Response: Please see the response to *CPA-25-c.*

1810.435(b)(6)
Comment: CMA-26 comment that as written the regulations require that a provider must be a Medi-Cal enrolled provider in order to contract with an MHP. If this is in fact the case than allowing further credentialing by an MHP is redundant and burdensome. If however, the MHP will be allowed to enhance its provider network with non Medi-Cal enrolled providers, than credentialing should only be required for these new providers.

Comment CPA-25-c comments that qualifying for Medi-Cal provider status ought to confer presumptive credentialing to expedite the enrollment of new providers and to reduce the paperwork burden on providers.

Response: The Department disagrees that this change is necessary or permissible. MHPs are responsible for establishing individual, group, and organizational provider selection criteria that comply with the requirements of this Section, the terms of the contract between the MHP and the Department, and the MHP's Implementation Plan pursuant to Section 1810.310 This regulation is written in accordance with Federal guidelines for the reimbursement of federal Financial Participation (FFP) and is consistent with Title 42, CFR, Section 438.214 that requires the State to ensure, through contracts, that each MHP implement written policies and procedures for the selection, retention, credentialing and recredentialing of providers.

1810.435 (c)(6)
Comment: CPA-25-b comment that in Sections 1810.435(b)(3) and (c)(6) it should be clarified that a person can only store and dispense medications if within the scope of practice of the person's license.

Response: The Department disagrees that this clarification is necessary. The regulation at (b)(3) specifically states "in compliance with state and federal laws". This statement implies compliance with the California, the Business and Professions Code, which defines the scope of licensure authority.

<u>1810.436 MHP Individual, Group and Organization Provider Contracting Requirements</u>

Comment: CPA-26 comments that protections need to be stated to ensure fair and reasonable contracting. CPA recommends the use of standardized form contracts, contract renewal on an yearly basis and a clear delineation of contract amendments.

Response: The Department has reviewed Section 1810.436 and has determined that the provisions as written provide guidance and standards that are fair and reasonable. MHPs and their contracted providers are responsible for implementing and participating in contract negotiation processes. There is no evidence provided by CPA that the recommendations they offer will enhance the existing requirements.

1810.438 Alternative Contracts and Payment Arrangements Between MHP's and Providers

Comment: *CPA-27 (refers to 1810.437, the Department believes this was a typographical error and the reference should be to 1810.438) comments that this section should not preclude or prejudice the employment of nurse practitioners or physicians' assistants.*

Response: The Section as written does not exclude nurse practitioners or physicians assistants; thus the Department does not believe it is necessary to change the language.

1810.440 MHP Quality Management Programs

Comment: NAMI-5 comments that this section be modified to include a reporting mechanism providing direct oversight by the Department of Mental Health, additional criteria to be met by the quality management program of a MHP, and public access to the results of the quality management program.

Response: The Department has direct oversight of MHP's as described at Section 1810.380 including on site review which includes review of the Quality Management Programs. In addition, MHPs and DMH are subject to an annual external quality review as described in Title 42,CFR, Section 438.364.

Comment: CPA-28-a comments that a physician director should have responsibility for the MHP's Quality Improvement (QI) Plan.

Response: The Department disagrees that the QI plan should be subject to direct physician oversight. This section at 1810.440 (a)(4) includes a requirement for the substantial involvement of a licensed mental health professional in QI activities. This language is also repeated in the DMH/MHP contracts. In addition the QI program is required to be accountable to the MHP Director. The Department's intention in the development of the requirements in this section was to establish requirements for the MHPs' Quality Management (QM) programs based on the draft accreditation standards of the National Committee on Quality Assurance (NCQA), which is nationally recognized for its work in accrediting

managed care organizations. This commitment was honored by including QM program requirements in Appendices A, B, and C of the contract between the MHP and the Department. The plans are developed in consultation with clinical staff, including physicians.

Comment: CPA -28-bcomments that the definition of providers should be clarified to make it clear that it includes a cross section of disciplines.

Response; The Department has reviewed this regulation and believes the term is clear. As stated the term is inclusive of a cross section of disciplines and does not exclude individual, group and institutional providers.

Comment: CPA-28-c comments that programs should be subject to public review in order to preserve transparency and to give ample opportunity for public input.

Response: The Department believes that this regulation as written is consistent with industry standards for Quality Management Programs and includes adequate levels of accountability. Adding the administrative burden of requiring MHP to provide for a public review is unnecessary.

Comment: CPA -28-d comments that this section needs clarification to convey that in those programs that include the practice of medicine a physician shall be involved in the supervision and oversight of the program.

Response: The Department has reviewed this requirement and believe it is clear and adequate as written. This requirement establishes an administrative requirement that the QMP include a Quality Improvement Program (QIP) responsible for reviewing quality of care and ensure organizational commitment to the QIP by making the QIP accountable to the highest level mental health professional within the MHP's organization by requiring specific monitoring activities by the MHP, and requiring annual review of the program. Physicians are among the providers who may participate in the QMP as necessary.

Comment: CPA-28-e comments that utilization programs statewide should have a consistent set of specific requirements to monitor specific requirements to monitor specific treatment parameters including but not limited to: denials of authorization; level of care and service intensity; administrative days; appeal determinations and other relevant quality indicators.

Response: The Department includes the specific minimum standards for the Quality Management program and the utilization Review standards in the contract between the Department and the MHPs. MHPs have the authority to establish additional standards as they determine necessary to tailor their

monitoring meet the unique features of their programs. Therefore, the Department believes the regulation is clear and appropriate as written.

1810.440(a)(1)
Comment:CHA-18-a comments that the term "director needs to be defined".

Response: The definition includes the term "director of MHP", which the Department believes is generally recognized as clear.

1810.440(a)(2)(a)
Comment: CMA-27 and CHA-18-b both comment that Section 1810.440(a)(2)(a) should clarify that the term providers means both individual, inpatient and institutional providers and that both have input to the quality improvement process.

Response: The Department disagrees additional clarification is necessary. The regulation as written is clear enough in that it does not exclude any type of provider and the language in the DMH MHP contract elaborates on this requirement stating that the MHP's practitioners, providers and licensed mental health professionals must actively participate in the planning, design and execution of the QI program.

1810.440(a)(5)
CMA -28 comments that the MHP monitoring activities should include a review of "provider appeals and grievances" as well as other items listed.

Response: The Department disagrees this level of specificity is necessary in regulation. MHPs are obligated to monitor provider appeals through the Departments annual contracts with the MHPs as described at Exhibit A-Attachment 1-Appendix A.

1810.440(a)(6)
Comment: CMA-29 comments that this section needs enhancement and clarification regarding what the MHP must do in its review, how and under what timeframe revisions take place, how will the MHP be held accountable and who within the Department is responsible for ensuring MHP compliance.

Response: The Department disagrees that this level of specificity is necessary in regulation. The contract between the DMH and the MHP in Exhibit A, Attachment 1, Appendix A, Section A requires that the QI Program description be reviewed annually and updated as necessary. In addition, the contract language in Exhibit A, Attachment 1, Appendix A, Section B requires that the annual QI Work Plan include an annual evaluation of the overall effectiveness of the QI program and includes a list of specific activities DMH Medi-Cal oversight activities as described at Section 1810.380 include a review of QI activities. The Department

believes the language in regulation as drafted is clear in its intent and does not need to be redrafted.

1810.440(b)
Comment: CMA-30 comments that the utilization management plan needs to be enhanced, existing data needs to be analyzed, more data required and denied days and services be analyzed.

Response: The comment is not specific enough to allow the Department to consider its' value in regulation. The Department believes that this information is more appropriately administered through MHP contracts which also provide the necessary flexibility to allow MHPs to tailor the analysis of information to address their specific needs.

1810.440(b)(2)
Comment: CMA-31 questions what the term "established standards for authorization" are, how they were established, with what public input they were developed and based on what science. The comment further recommends the entire section be "fleshed out" to clarify the standards.

Response: The Department required MHPs to provide a description of their procedures for MHP payment authorization of specialty mental health services by the MHP, including a description of the point of authorization, in their Implementation Plans which were approved by the Department. In addition there are additional standards for authorization processes in Sections 1820.215, 1820.220, 1820.225, 1820.230 and 1830.215 and additional standards in the contract between the Department and the MHPs in Exhibit A, Attachment 2, Item B. The standards are consistent with Title 42, CFR, Section 438.210 Coverage and authorization of services. The comment offers no additional recommendations alternative language. The Department has reviewed the language in this part and established that it is sufficiently clear and consistent with Federal and State obligations.

1819.249 Targeted Case Management
Comment: NAMI-10 comments that the definition of service activities should expressly include transportation, housing and medication support.

Response: The Department does not agree with the comment because "Targeted Case Management" is limited to activities that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services;

and plan development. Targeted case management is not a "service" but a process to link and broker needed services.

1820.100 Definitions

Comment: CMHDA-3 comments that Subsection (a) includes more "Allowable Psychiatric Accommodation Codes" than are actually used by hospitals or counties and that it would make sense to reduce this number to those two or three codes that are actually used the most.

Response: The codes referenced are nationwide revenue codes and outside of the Department's authority to modify. There are two codes that are very seldom used but they define the type of bed for the facilities.

Comment: CPA-29 (refers to 1820.200, the Department believes this is a typographical error and should be a reference to 1820.100) comments that federal law and regulation requires that inpatient hospital service be delivered by or under supervision of a physician. The language is necessary to convey so that there are no more Ventura County-like contravening of federal law.

Response: Scope of practice issues are not under the purview of the Department. The Department does not retain the authority to license hospitals or dictate the delivery of inpatient hospital services. MHPs are required to select hospitals that operate consistent with the provisions described in Sections 1810.219 and 1810.425 which acknowledges the scope of authority of the DHS. The problems experienced by Ventura County were as a result of violations of federal Medicare laws, which differ significantly from the federal Medicaid laws that apply the Medi-Cal specialty mental health services program governed by these regulations. If Ventura County has agreed via an integrity agreement with the federal government that it will require physician involvement in all Medicaid services, the Department finds nothing in these regulations that would prevent Ventura County from complying with its agreement.

1820.110 Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, Fee-for-Service/Medi-Cal Hospitals

Comment: CHA -19 comments that the regulation does not allow flexibility for outliers, and this should be a consideration for psychiatric inpatient hospital services.

Response: The Department does not believe that this regulatory action is the appropriate forum for addressing changes to the rate structure for inpatient psychiatric facilities.

1820.115 Rate-Setting for Psychiatric Inpatient Hospital Services for Non-negotiated Rate, Fee-for-Service/Medi-Cal Hospitals

Comment: CMHDA-4 comments that although there are no changes proposed for Subsection (c), it seems fairly clear that the current non-contract hospital rate-setting system does not serve either MHPs or hospitals well, and that it does not include the proper incentives for hospitals to contract with counties. CMHDA suggests that, in order to make the non-contract regional rates more consistent with what the actual contract rates are, regulations replace "weighted average" in the first sentence of subsection (c) with either "mode" or "median."

Comment: CHA-20 recommends that the Department reevaluate these regulations because this section is no longer functional because a significant number of hospitals no longer contract with MHP's, thereby reducing the number of contracts available to establish the non-contract hospital rates.

Response: The Department has received input on hospital rates from several sources. These issues are being addressed in accordance with the Governor's direction in a recent veto of Assembly Bill 467 (2005), in which the Department was directed to conduct a study of hospital rates and prepare a report which will be available after September 2006. The Department is committed to making whatever regulatory changes are found to be necessary to address the issues raised by CMHDA and CHA once a thorough evaluation of the issues has been completed.

1820.200 Definitions

1820.200 (c)
Comment: CHA-21 comments that the State Department of Health Services will no longer be administering the County Medical Services Program (CMSP) effective October 1, 2005, and that the new third party administrator is Blue Cross.

Response: The source of funds for the CMSP will still originate with the Department of Health Services, and the Department does not feel a change in wording is warranted.

Comment: CPA-30 comments that inpatient hospital services be delivered by or under the supervision of a physician.

Response: Scope of practice issues are not under the purview of the Department. The Department does not retain the authority to license hospitals or dictate the delivery of inpatient hospital services. MHPs are required to select hospitals that operate consistent with the provisions described in Sections 1810.219 and 1810.425 which, acknowledges the scope of authority of the DHS.

1820.205 Medical Necessity Criteria

Comment: CPA-22 comments that the reference in this section should be to the current edition of the DSM, instead of a specific edition such as Fourth Edition, since revisions are now under consideration for a new edition and the new edition may become operative in the near future.

Response: The DSM is a diagnostic manual and its primary purpose is to facilitate communication among mental health professionals. It is understood by mental health professionals that the most recent version of the DSM is to be used. The DSM V will not be ready for publication until at least 2010 and there are often delays in the release of each new edition. The numerical identifiers (DSM IV-R, DSM IV-TR, etc.) sometimes change after the completion of all the necessary workgroup and stakeholder processes which will begin in 2006/07 for the DSM V. The department believes it is the best decision to include the version that has already be been in publication for some time. The last major revision was in the DSM IV published in 1994. The DSM IV-TR was published in 2000 which made some changes in diagnostic codes in order to keep the codes compatible with the ICD-9 CM, the diagnostic coding system required by the US government. The DSM IV and the DSM-TR versions are both considered to be current editions.

The classification system used in the DSM is the International Classification of Diseases, 9th Revision, Clinical Modification (CM). All DSM diagnoses are linked to the ICD-9 CM codes so these codes must also be considered when determining how the DSM is listed in regulations. The ICD-9 codes are used to track the morbidity and mortality of diseases. The codes are also used for reimbursement purposes. The ICD-9 CM codes are maintained and managed by the federal government. The ICD-10 is now in use in other parts of the world but its use was significantly delayed in the United States. The National Center for Health Statistics is developing a modification of ICD-10 known as the ICD-10 CM for use in the U.S. The department believes that the DSM version may be changed in the regulations at a later time after the ICD-10 CM is also in use.

1820.205 (a)(1)
Comment: CHA-22 comments that the diagnoses should be made by or under the supervision of a physician.

Response: Section 1840.314(d) requires MHPs to ensure that services are provided within scope of practice of the person delivering the services, if a license is required for the service. The Department does not agree that language this prescriptive should be incorporated into the regulation text.

1820.205 (b)(1)(F), (G) and (H)
Comment: PAI comments on language contained in sections (b)(1)(F), (G) and (H) specifying that schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders do not meet medical necessity criteria for MHP reimbursement of

specialty mental health services if due to a general medical condition. PAI indicates that the new language is a large reduction in the scope of coverage for specialty mental health services, that the necessity for the reduction is not described, and that it violates federal comparability requirements.
PAI argues that the change also violates federal law at 42 C.F.R. § 438.210(a)(3)(ii) and is not necessary because the issue of dual diagnosis, or co-occurring disorders, is adequately covered under section 1830.205(c) of the existing and proposed medical necessity regulation. In that section, treatment of a general medical condition is not the responsibility of the MHP, while treatment of a mental disorder caused by the medical condition is the responsibility of the MHP.

Response: The Department is not in violation of Federal statute at 438.210(a)(3)(ii).The language in this regulation is not new. Federal law permits the Department to establish medical necessity criteria. The diagnoses and factors identifying the severity of the beneficiary's condition were determined by the Department based on input from clinicians and other interested parties developed during the public planning process. The severity criteria in these subsections are consistent with requirements as applied by the Medi-Cal program administered by the State Department of Health Services.

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1820.215. MHP Payment Authorization – General Provisions

1820.215(b)
Comment: CHA -23-a comments that CMSP is undergoing changes and these regulations do not adequately reflect practices, which will become effective October 1, 2005.

Response: The Department has reviewed the language in this regulation and because CMSP will still be under the authority of DHS the regulation is correct as written.

1820.215(c)
Comment: CHA-23-b comments that the payment authorization requests presented to an MHP beyond the timelines specified in these regulations are inflexible and unfair to the provider.

Response: Criteria for negotiation of disputes between MHP's and providers are specified at 1850.315. Where a dispute exists between the provider and the MHP, these regulations allow an appeal process to the Department as specified at 1850.320. The Department does not agree that the guidelines are inflexible. In addition to the circumstances actually spelled out in (c) (2), the regulation specifically allows for other circumstances outside the provider's control in addition to what is listed. These specifications are the same as those set out by DHS for hospital providing Medi-Cal services. This process would thus be

identical to how handle delays on Treatment Authorization Requests for all Medi-Cal services requiring such requests.

1820.220 MHP Authorization by a Point of Authorization
Comment: CPA 30-c comments that in the MHP documentation of all adverse decisions, medical necessity criteria must be decided by a psychiatrist.

Response: The Department disagrees. The Department believes that this is an administrative function, not the practice of a profession, and that the level of licensed mental health professionals making the authorization decisions, quality management program, beneficiary and provider problem resolution and appeal processes, and state oversight authority provided in these regulations are adequate to ensure that the decisions made on MHP payment authorizations requests are appropriate. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

1820.220(d)
Comment: CHA-24-a and CPA-30 comment that the term "waivered/registered professionals" is not defined and is used throughout these regulations.

Response: The Department does not believe additional definition in these regulations is necessary because the terms are incorporated into the Department's contract in Exhibit A, Attachment 1, Appendix D. Welfare and Institutions (W&I) Code Section 5751.2 requires candidates to be registered prior to engaging in activities of a position that requires a license waiver or registration.

1820.220(f)
Comment: Under (f) – Utilization Review Committee, CPA-30-d indicates that it is outside the scope of licensure of a psychologist to admit a person to a hospital.

Response: The Department disagrees with the comment. This regulatory action does not address the scope of practice of psychologists; but, rather allows for facilities, counties and government-operated facilities to make those determinations.

1820.220(g)
Comment: CHA-24-b comments that subjectivity and flexibility has caused significant problems, and the phrase any recommends that the phrase "any other mandatory requirements of the contract" be removed from these regulations.

Response: The Department disagrees with the comment. Flexibility to negotiate contract terms is an essential part of any managed care program. The proposed

regulations are intended to establish those statewide requirements appropriate to regulation and essential to ensure compliance with Medicaid requirements, including the approved waiver request.

1820.220(g) and (j)(1),(4) and (5)
Comment CHA-24-e reiterates CHA's objections to giving MHPs the authority to deny a request for payment authorization fore any other reason than the provider failed to meet state requirements.

Response: Please refer to the response to CHA-24-a though d.

1820.220(i)
Comment: CHA-24-c comments that the point of authorization staff should be limited to mental health professionals.

Response: The Department disagrees. The Department believes that authorizing coverage of services is an administrative function, not the practice of a profession, and that the level of licensed mental health professionals making the authorization decisions, quality management program, beneficiary and provider problem resolution and appeal processes, and state oversight authority provided in these regulations are adequate to ensure that the decisions made on MHP payment authorizations requests are appropriate. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

Comment: CPA-30-b comments that Point of Authorization staff that approve or deny payment if not psychiatrists, should be supervised by a psychiatrist and that at least denials ought to be reviewed and countersigned by a psychiatrist.

Response: Please see the response to CHA-24-c.

1820.220(j)(5)
Comment: CHA-24-d comments that payment authorization for administrative day services creates an incentive for MHPs to keep beneficiaries in the hospital and places too much of the responsibility for community placement on the inpatient provider and not enough on the MHP. CHA believes that MHPs should be required to find a community placement within one week after the beneficiary no longer meets the criteria for acute hospital services, or be required to reimburse the hospital at a full acute hospital rate.

Response: As previously noted in the response to the comment regarding 1820.115these issues are being addressed in accordance with the Governor's direction in a recent veto of Assembly Bill 467 (2005), in which the Department was directed to conduct a study of hospital rates and prepare a report which

will be available after September 2006. The Department is committed to making whatever regulatory changes are found to be necessary to address the issues raised by CMHDA and CHA once a thorough evaluation of the issues has been completed.

1820.220 (j)(5)(B) and (B)(2)
Comment: CHA recommends for the sake of consistency that the term residential be defined.

Response: The Department believes the citation as written " non- acute residential facilities" is clear and no further definition is necessary.

1820.225 MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

1820.225(b)
Comments: *CMA-32 comments that to have separate medical necessity criteria for psychiatric care in an emergency room would be an EMTALA violation and would result in two levels of care being delivered.*

Response: Establishing medical necessity criteria is necessary because the procedures for MHP payment authorization of emergency admissions differs substantially from that required for planned admissions. It is imperative that the requirements be clearly differentiated so timely provision of emergency care is not impacted and hospitals that provide emergency care are assured of appropriate reimbursement.

1820.225(c) (d)(1) and (d)(5)
Comment: CHA-25 comments that it does not feel there should be flexibility to modify this regulation on a county by county basis.

Response: The Department disagrees with the comment. Flexibility to negotiate contract terms is an essential part of any managed care program. The proposed regulations are intended to establish those statewide requirements appropriate to regulation and essential to ensure compliance with Medicaid requirements, including the approved waiver request.

1830.205(a)(1)
Comment: CHA-26 comments that (a)(1) should include "or most recent edition".

Response: The DSM is a diagnostic manual and its primary purpose is to facilitate communication among mental health professionals. It is understood by mental health professionals that the most recent version of the DSM is to be used. The DSM V will not be ready for publication until at least 2010 and there are often delays in the release of each new edition. The numerical identifiers

(DSM IV-R, DSM IV-TR, etc.) sometimes change after the completion of all the necessary workgroup and stakeholder processes which will begin in 2006/07 for the DSM V. The department believes it is the best decision to include the version that has already be been in publication for some time. The last major revision was in the DSM IV published in 1994. The DSM IV-TR was published in 2000 which made some changes in diagnostic codes in order to keep the codes compatible with the ICD-9 CM, the diagnostic coding system required by the US government. The DSM IV and the DSM-TR versions are both considered to be current editions.

The classification system used in the DSM is the International Classification of Diseases, 9th Revision, Clinical Modification (CM). All DSM diagnoses are linked to the ICD-9 CM codes so these codes must also be considered when determining how the DSM is listed in regulations. The ICD-9 codes are used to track the morbidity and mortality of diseases. The codes are also used for reimbursement purposes. The ICD-9 CM codes are maintained and managed by the federal government. The ICD-10 is now in use in other parts of the world but its use was significantly delayed in the United States. The National Center for Health Statistics is developing a modification of ICD-10 known as the ICD-10 CM for use in the U.S. The department believes that the DSM version may be changed in the regulations at a later time after the ICD-10 CM is also in use.

1830.205(b)(1)
Comment: David Horner-1 comments that the language "have" (a diagnosis) presents a problem in that it opens up situations in which the MHP would have to provide treatment for a consumer who has been diagnosed by another person or entity with an included diagnosis even if the MHP's own assessment team disagrees with the diagnosis.

Response: The Department disagrees that the language could create situations when the MHP does not agree that medical necessity criteria are established. It's necessary to establish the medical necessity criteria that must be met before an MHP will be responsible to pay a provider for specialty mental health services. If the MHP does not believe the beneficiary has one of the diagnoses identified in 1830.205(b) (1), the MHP may decline providing services and may deny requests for treatment authorization.

Comment: CACFS-7 comments that the word "reasonable" is undefined and adds confusion to the current community standard.

Response: The Department does not agree that the word reasonable constitutes vague or unclear language. The diagnoses and factors identifying the beneficiary's level of impairment and the likely effectiveness of an intervention covered by the MHP were determined by the Department based on

input from clinicians and other interested parties developed during the public planning process. These elements are modeled upon treatment criteria currently in use in community mental health programs, and take into consideration that effective treatment may occur in the physical health care realm, particularly through primary care.

1830.205 (b)(1)(F), (G) and (H) Medical Necessity Criteria for Reimbursement of Specialty Mental Health Services

Comment: PAI-13 comments on language contained in sections (b)(1)(F), (G) and (H) specifying that schizophrenia and other psychotic disorders, mood disorders, and anxiety disorders do not meet medical necessity criteria for MHP reimbursement of specialty mental health services if due to a general medical condition. PAI indicates that the new language is a large reduction in the scope of coverage for specialty mental health services, that the necessity for the reduction is not described, and that it violates federal comparability requirements.

PAI argues that the change also violates federal law at 42 C.F.R. § 438.210(a)(3)(ii) and is not necessary because the issue of dual diagnosis, or co-occurring disorders, is adequately covered under section 1830.205(c) of the existing and proposed medical necessity regulation. In that section, treatment of a general medical condition is not the responsibility of the MHP, while treatment of a mental disorder caused by the medical condition is the responsibility of the MHP.

Response: The Department is not in violation of Federal statute at 438.210(a)(3)(ii) .The language in this regulation is not new. Federal law permits the Department to establish medical necessity criteria. The diagnoses and factors identifying the severity of the beneficiary's condition were determined by the Department based on input from clinicians and other interested parties developed during the public planning process. The severity criteria in these subsections are consistent with requirements as applied by the Medi-Cal program administered by the State Department of Health Services.

1830.210 – Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age

Comment: *CACFS-8 comments that if a child can be served at home, in his own community, then he should be, even if it costs more.*

Response: This requirement is consistent with the requirements of Title 22, Section 51340(m) which requires that the Department not approve a request for EPSDT diagnostic and treatment services or EPSDT supplemental services in home and community-based settings if the Department determines that the total cost incurred by the Medi-Cal program for providing such services to the beneficiary is greater than the total costs incurred by the Medi-Cal program in providing medically equivalent services at the beneficiary's otherwise appropriate institutional level of care, where medically equivalent services at the appropriate level are available in a timely manner.

1830.215 MHP Payment Authorization

Comment: CHA-27 comments that hospitals feel that the criteria regarding payment authorization requests presented beyond the timelines specified in regulations are inflexible and unfair to the provider.

Response: The Department does not agree that the guidelines are inflexible. In addition to the circumstances in (g) 1 A and B, the regulation specifically allows for other circumstances outside the provider's control in addition to what is listed. The criteria for negotiation of disputes between MHP's and providers are specified at 1850.315. Where a dispute exists between the provider and the MHP, these regulations allow an appeal process to the Department as specified at 1850.320.

Comment: CPA-34 comments that the ultimate decision to deny treatment should be made by a decision and that, minimally, a physician should review all adverse decisions. CPA comments that point of authorization staff that approve or deny payment should be supervised by a psychiatrist. CPA comments that POA staff that approve should either be a psychiatrist or supervised by a psychiatrist. CPA comments that at the least, denials or other adverse decisions might be reviewed and countersigned by a psychiatrist. CPA poses similar comments related to MHP documentation of all adverse decisions and that reviewing plan representatives should not have lesser qualifications, education and training than a requesting provider unless the person is supervised by a person with equivalent qualifications

Response: The Department disagrees. The Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician, but provides that other qualified staff may approve these requests. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

Comment: CACFS-9 comments that providers must be notified directly by the MHP of MHP payment authorization requirements by requiring MHPs to directly mail information to providers as opposed to the existing requirement to make information available in "..a publication commonly available to all providers…".

Response: The Department disagrees this change is necessary. Where there is a disagreement between the plan and the individual provider, the matter is addressed through grievance processes identified in Section 1850.350. It is not clear what value this change would add or what problem CACFS is seeking to address. The proposed change would add unnecessary administrative cost and burden to MHPs.

1830.220 –Authorization of Out of Plan Services

Comment: CACFS-10 comments that it believes that the regulations should incorporate children placed via the child welfare service, delinquent youth placed via the juvenile justice system, children no longer in foster care but receiving assistance through Kin GAP, and adopted youth.

Response: This section is intended to describe those situations in which an MHP must authorize out-of-plan services even if those services are available within the MHP's provider network, not to relieve the MHP of the responsibility to ensure that beneficiaries receive the services as described in Section 1810.345. The populations CACFS addresses are not excluded from receiving medically necessary mental health services and therefore, no change to the text is necessary.

1830.225 Initial Selection and Change of Person Providing Services

1830.225(a) and (b)
Comment: CHA-28 comments that the expression "whenever feasible" is not specific enough and should be amended to include more specifics about the minimum acceptable level of choice that will be required of MHP's.

Response: The Department does not agree that additional qualification of the requirement that the MHP provide choice of person providing services under the specific terms of this section "whenever feasible". The Department believes this is an issue that must be determined on a case by case basis, subject to the beneficiary problem resolution processes and State oversight.

1830.230 Psychiatric Inpatient Hospital Professional Services

1830.230(b)
Comment: CMA-32 comments that the last sentence in this section is unclear.

Response: The Department has reviewed the regulation and believes the language is clear as stated.

1830.250 – Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services
Comment: CMHDA-5 comments that 1830.250 is not relevant to our current system because authorization is not required for psychiatric nursing facility services. CMHDA also questions why subsection (f) includes a change in the timeline for MHP payment authorization from five to three working days.

Response: This regulation is necessary to establish an exception to the MHP's normal authority to limit services to contract providers for psychiatric nursing facility services. The Department has determined that it is necessary

to encourage participation in the Medi-Cal Specialty Mental Health Services program by all of the nursing facilities currently providing the equivalent of psychiatric nursing facility services to Medi-Cal beneficiaries through the regular Medi-Cal program. There have been less than 35 facilities statewide that are licensed and certified to provide these services. The obligation to contract with up to 58 MHPs would be a significant administrative burden to an individual facility and could discourage participation.

1840.110 Claims Submission

Comment: Marvin J. Southard- County of Los Angeles-1, comments that 1840.110(b) does not comply with Welfare and Institutions Code Section 14115(c) which provides that claims submitted within seven to nine months after the month of services will be paid at 75 percent of the usual rate, and that claims submitted between ten to twelve months following the service are paid at 50 percent of the usual rate. Mr. Southard argues that Section 14115 applies to services paid for community mental health services.

Response: The Welfare and Institutions Code to which Dr. Southard refers does not apply to Short-Doyle or Mental Health Medi-Cal. Welfare and Institutions Code Section 5720(a), which governs Mental Health Programs, gives the authority to the Director of DMH to establish the amount of reimbursement for services provided by county mental health programs to Medi-Cal eligible individuals. At this time, Short-Doyle Medi-Cal reimbursement is based on the lowest of actual costs, published charges, State Maximum Allowances (SMAs), or negotiated rates. There are no provisions to pay based on percentages or fractions of these costs. Changes to the established process would create the need to change both the Welfare and Institutions Code and our State Plan and would extend the amount of time needed to complete the cost report settlement process. Any change would also necessitate changes to the DMH cost report, and the process would be more difficult in that it would need to accommodate fractional payments. Because the change will greatly increase workload, it could create staffing shortages within DMH.

1840.210 Non-Reimbursable Psychiatric Inpatient Hospital Services

Comment: PAI-14 comments that Section 1840.210(c) is misleading in that it can be interpreted to mean that the individual has to actually pay the share of cost before FFP can be claimed. PAI further comments that federal law requires only that the share of cost be incurred, rather than paid. PAI recommends that the regulation should replace the phrase "met the beneficiary's share of cost obligations" with the phrase term "incurred the beneficiary's share of cost" in both places in the regulations in order to make the requirement accurate and clear.

Response: The Department does not attribute special meaning to the term "met" as used in the draft regulation. The Department does intend that MHP's may not claim for specialty mental health services are not eligible for FFP until a

beneficiary's share of cost for inpatient hospital services has been met. This is consistent with the requirements of Title 22, Sections 50657 through 50659 and consistent with federal laws.

1840.316 Claiming for Service Functions Based on Minutes of Time

Comment: NAMI-13 comments that services for physical examinations must be included within the allowable billing, whenever such exams are required of a facility upon admission of a beneficiary.

Response: The Department has developed a program, consistent with state law that focuses on specialty mental health services. The physical health care needs of Medi-Cal populations are covered benefits of the Medi-Cal program outside the scope of the mental health waiver program. Section 1810.415(b) places requirements upon MHP's to ensure for coordination of the beneficiary's physical and mental health care needs. The components of the mental health assessment described in the annual contract at Exhibit 1, Attachment 1, Appendix C between DMH and MHPs includes language sufficient to ensure relevant physical health conditions reported by the client are prominently identified and updated as appropriate.

Comment: CHA-29 recommends that the term "mental health assessment" be included as a billing unit in this section.

Response: The Department disagrees such a change is necessary. Mental health services are an included service activity in 1840.316(a)(1). Assessment is a "service activity" of mental health services as described in 1810.227.

1840.324 Mental Health Services Contact and Site Requirements

Comment: CMA -34 and CHA-30 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to establish the types of contact the person providing the mental health service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs.

1840.325 Medication Support Services Contact and Site Requirements

Comment: CHA-31 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to establish the types of contact the person providing the medication support service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

1840.332 Adult Residential Treatment Services Contact and Site Requirements
Comment: CHA-32 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to distinguish adult residential treatment services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the types of facilities included.

1840.333 Crisis Residential Treatment Services Contact and Site Requirements
Comment: CHA -33 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to distinguish crisis residential treatment services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the types of facilities included.

1840.336 Crisis Intervention Contact and Site Requirements
Comment: CHA-34 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this

regulation is to establish the types of contact the person providing the crisis intervention must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

1840.340 Psychiatric Health Facility Services Contact and Site Requirements
Comment: CHA-35 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to distinguish psychiatric health facility services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the type of facilities included.

1840.342 Targeted Case Management Contact and Site Requirements
Comment: CMA-34 and CHA-36 comments that this section fails to acknowledge emerging technologies and current practices such as telemedicine.

Response: The Department does not agree that the regulations are an appropriate venue to provide such acknowledgment. The purpose of this regulation is to establish the types of contact the person providing the targeted case management service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

1840.348 Crisis Stabilization Staffing Requirements
Comment: NAMI-14 comments that it is important that "waivered/registered professionals" have appropriate training and licensure to perform the required service activities.

Response: The Department acknowledges NAMI's concern. These terms are incorporated into the Department's contract Exhibit A Attachment 1, Appendix D. Welfare and Institutions W&I Code, Section 5751.2 requires candidates to be registered with the appropriate licensing Board prior to engaging in activities of a position that requires a license waiver or registration.

Comment: CMA-35 comments that the term "waivered/registered" professional is unclear and the regulations provide no definition.

Response: These terms are incorporated into the Department's contract Exhibit A Attachment 1, Appendix D. Welfare and Institutions Code Section 5751.2 requires candidates to be registered prior to engaging in activities of a position that requires a license waiver or registration.

1840.350 Day Treatment Intensive Staffing Requirements
Comment: CHA-38 comments that the term "waivered/registered" professional is unclear and the regulations provide no definition.

Response: These terms are incorporated into the Department's contract Exhibit A Attachment 1, Appendix D. Welfare and Institutions Code Section 5751.2 requires candidates to be registered with the appropriate licensing Board prior to engaging in activities of a position that requires a license waiver or registration.

1840.352 Day Rehabilitation Staffing Requirements
Comment: CHA-40 comments that the term "waivered/registered" professional is unclear and the regulations provide no definition.

Response: These terms are incorporated into the Department's contract Exhibit A Attachment 1, Appendix D. Welfare and Institutions Code Section 5751.2 requires candidates to be registered with the appropriate licensing Board prior to engaging in activities of a position that requires a license waiver or registration.

1840.368 Lockouts for Crisis Stabilization
Comment: CMHDA-6 and CHA-39 question why, in subsection (c), the maximum number of hours claimable for Crisis Stabilization 20 hours? Wouldn't it make more sense for it to be 23 hours or up to 24 hours? By doing this, Crisis Intervention could even be eliminated as a reimbursable service, which could reduce confusion about billing for both services at the local level.

Response: The Department established the hours because it is necessary to standardize the service for claiming purposes by distinguishing it for 24-hour services such as psychiatric health facility services. Allowing more than 20 hours of crisis stabilization to be claimed in a 24-hour period is likely to result in inappropriate use of this service function.

1850.205 Beneficiary Problem Resolution - General Provisions
Comment: NAMI-15 comments that objective criteria be inserted that the MHP must follow as opposed to the current requirement of the MHPs " to assign an individual

who has appropriate clinical expertise as determined by the MHP…to decide issues regarding the denial of a request.."

Response: The Department is unclear if the comment means for the MHP to have criteria for the selection of the individual or criteria for the individual to follow. In either case, the Department has reviewed the requirements and established that it is consistent with federal law at Title 42, Section 438.210(b)(ii)(3).

Comment: CPA-39 recommends that basic information describing the grievance, appeal and expedited appeal process be placed on a readily-available website.

Response: The Department has already posted these requirements in various locations on the DMH website.

Comment: CHA-42-e makes a general comment that there should be an annual review of each county's resolution process to identify trends and corrective actions.

Response: MHP's are required through their contract with the Department in Exhibit A-Attachment 1-Appendix A, to review grievances and fair hearings at least annually. The contract for Fiscal year 2006-07 will be amended to include appeals as part of this review requirement.

1850.205 (c)(1)
Comment: CHA-42-a comments that this information should be posted on the DMH website.

Response: The Department disagrees with the comment because each MHP has unique features which would require the Department to post 56 different processes and update them routinely. This would create an unnecessary administrative burden for both the Department and the MHPs. The Department believes the current requirement for informing beneficiaries and providers is sufficient.

1850.205(1)(B)
Comment: CHA -42-b comments that posting notice should be provided by the MHP.

Response: This regulation addresses posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all MHP provider sites sufficient to ensure that the information is readily available to both beneficiaries and provider staff. For the purposes of this Section, an MHP provider site means any office or facility owned or operated by the MHP or a provider contracting with the MHP at which beneficiaries may obtain specialty mental health services. MHPs have the authority to negotiate with their contract providers to ensure the conditions of this regulation are met.

1850.205 (c)(5)
Comment: CHA-42-c comments that the term "retaliation" should be added.

Response: The Department has reviewed this regulation and finds that the text as written provides that a beneficiary is not subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal and is sufficient.

1850.205(c) (9)
Comment: CHA-42-d comments That the term "clinical expertise" is utilized without definition. CHA sates this is a very subjective term and should be defined to ensure consistency with its application.

Response: The Department disagrees that this term requires additional definition. The use of this term is consistent with the terminology required in Title 42, CFR, Section 438.210.

Response: The Department disagrees. The Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician, but provides that other qualified staff may approve these requests. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

1850.207 The Appeal Process
Comment: PAI-15 comments that the regulation does not provide for aid paid pending an appeal decision which PAI cites as a violation of federal law at 42 C.F.R. § 438.420.

Response: Subsequent to the production of this regulation package, the Centers for Medicare and Medicaid issued a decision regarding aid paid pending. The Department has amended this section to reflect implementation of the appropriate provisions of 42 CFR 438.420, as required and approved by the Centers for Medicare and Medicaid.

1850.210 Provision of Notice of Action
Comment: PAI-16-a comments that notice of action is not required when the MHP modifies the duration of any approved specialty mental health services as long as the MHP provides an opportunity for the provider to request authorization of additional services before the end of the approved duration of services. This is a violation of the court order in Jackson v. Rank. Under that order, the Department is not required to give notice to the beneficiary in that circumstance, but is required to give notice to the provider. At the time that the provider is given notice of the modification, the

provider must also be given notice that the provider must request authorization before the end of the approved duration of services in order to prevent any break in the therapeutic regimen. (Order, ¶ 13(a).)

Response: The Department disagrees with the comment. The Department has followed the court order in Jackson v. Rank in allowing notices of deferral to be delayed for 30 days from the date of the request for prior authorization. The Department has followed the court order in Jackson v. Rank in not requiring notices when the duration of a request is changed, so long as there is an opportunity for the provider to request additional services before the end of the approved duration of services. When the duration of a request is changed, but the provider has an opportunity to request services prior to the expiration of the approved period, no action has been taken at that time that affects services to the beneficiary. If the provider later requests additional services and the services are approved by the MHP, no services have actually been denied. If services were later denied, the MHP would send a notice when the denial actually occurs.

Comment: PAI- 16-b comments that Subsection (f) of the proposed regulation is inconsistent with the timeframes for an action established elsewhere in the regulations. Subsection (f) provides that notices of action need not be mailed for three days after the timeframe for taking an action has expired. An action cannot properly be said to have been taken within the appropriate timeframe if the notice is not given within the time frame.

Response: The established timeframes for notices of action throughout the regulation package comply with the requirements of Title 42, CFR, Section 438.404. No change is necessary.

1850.213 Fair Hearings

Comment: PAI-17 comments that this section does not state the circumstances under which an individual has a right to request a fair hearing and comments that the proposed regulations should specify that the individual has a right to request a hearing whenever (1) a claim for services is denied or is not acted upon with reasonable promptness, or (2) the individual believes the MHP has taken an action erroneously, as per 42 C.F.R. § 431.220(a)(1) and (2) and 42 C.F.R. § 431.201 (definition of "action").

Response: The comment does not include a complete citation of the language at Title 42, CFR, Section 431.220(a)(1) and (2) and Title 42, CFR, Section 431.201. Title 42, Section 438.408(f)(i) allows the exhaustion of internal grievance process prior to filing for a state fair hearing. CMS approved the Department's language and approach to access to state fair hearings through the April 2005 waiver renewal process. The regulation text as is consistent with the provisions of Title 42.

1850.215 Continuation of Services Pending Fair Hearing Decision

Comment: PAI-18 comments that Subsection (a) is contrary to court decisions which provide that an individual does not have to request aid paid pending a hearing in order to receive it. Also, the words "right to file" are confusing. They suggest this is a procedure which does not exist in the Medi-Cal fair hearing process. The words "right to file for a continuation of specialty mental health services" should be replaced with the words "right to request extension of specialty mental health services." This is consistent with the terminology in the federal regulations at 42 C.F.R. § 438.420(b)(5).

Response: The Department does not feel it is necessary or appropriate to restate 42 CFR 438.420(b)(5) as part of this regulatory action. The language used by the Department has been approved by CMS as part of the process for renewal of the Federal 1915(b) waiver in April 2005 and is consistent with the CMS requirement in Title 42, CFR, Section 438.404 regarding language and format requirements that require notices be in writing and must meet the language and format requirements of Sec. 438.10(c) and (d) to ensure ease of understanding. The Deaprtment believes the language is clear and appropriate as written.

1850.305 Provider Problem Resolution

Comment: CPA-40 comments that appeals for payment authorization should be reviewed by a licensed mental health provider and where medical necessity is at issue, countersigned by a physician. CPA also comments that the reviewing plan representative must not have lesser qualifications education or training than a reviewing plan representative.

Response: The Department disagrees with the comment. The regulations require MHPs to ensure that persons delivering services do so within their scope of practice, if applicable (Section 1840.314), and that services are delivered by qualified persons in accordance with state law. The regulations also require general compliance with state laws (Section 1810.110(a)). When medical decisions are solely within the scope of practice of a physician, the regulations, therefore, require that the decision be made by a physician. California law, however, permits licensed practitioners of the healing arts to provide a wide range of services within their individual discipline's scope of practice. As indicated above, the Department has required that only a physician may deny an MHP payment authorization request for psychiatric inpatient hospital services, when the admitting provider is a physician. These requirements allow the MHP to make the best use of the limited availability of physicians, while assuring that, in those situations most critical to the beneficiary, a physician must make the decision.

1850.310 Provider Problem Resolution Process

Comment: CHA-43 comments that the process lacks substance and would not affect problem resolution. CHA recommends trends should be tracked and an annual

review take place, and that all responses should be in writing and resolved within 60 days.

Response: The Department disagrees with the comment because the language as drafted in conformance with federal requirements for timely resolution of appeals and grievances as described at Title 42, CFR, Section 438.402. There are existing provisions that the Department may employ with MHPs as necessary required to report on trends, as a component of contracts at Exhibit A – Attachment 1 – Appendix A.

1850.315 Provider Appeal Process

1850.315(a)
Comment: CMA-36 comments that ultimate authority for the adjudication of a provider appeal should rest with a physician with as much training as the provider in question.

Response: The Department disagrees. Adjudication of provider appeals of a denied or modified request for MHP payment authorization or a dispute with the MHP concerning the processing or payment of a provider's claim to the MHP is an administrative function and does not require the clinical expertise of a physician. Use of licensed practitioners of the healing arts to provide a wide range of services including adjudication of provider appeals allows the MHP to make the best use of the limited availability of physicians.

1850.320 Provider Appeals to the Department
Comment: CHA-44 comments that there should not be flexibility to modify the regulation on a county-by-county basis in the contracts between the hospitals and MHP's.

Response: The Department disagrees with the comment. This regulation is necessary to explain that providers may appeal the denial or modification of request for payment authorization for emergency specialty mental health services and related administrative day services through the MHP's Provider Appeal Process to the Department. The subsection provides that hospitals may not appeal to the Department when the disputed issue is compliance with a mandatory provision of the contract between the hospital and the MHP that is permitted by Section 1820.220(g) and (h) and Section 1820.225(d)(5). This provision is necessary to establish the Department's responsibility to address issues related to the requirements of Subchapter 2, rather than to resolve unrelated contract disputes which may arise. MHPs are required to provide for a Provider problem resolution process as described at Title 9, CCR, Section 1850.305 to ensure provider concerns are addressed.

Comment: CPA-40 comments that loss of appeal rights for hospitals is a very serious and inappropriate action, that the only resource would be a lawsuit, and the Department should consider whether or not it wants to establish policy encouraging lawsuits.

Response: The Department has established the appeal process in compliance with federal and state law and is consistent with the principles of managed care to allow MHPs the discretion to negotiate certain contract provisions with their providers. In no instance would the Department deliberately establish policy so as to encourage litigation.

1850.405 Arbitration Between MHP's

Comment: CHA- 45 comments that it believes providers should be included in the notification of decisions.

Response: The department disagrees as this section is limited only to determining what the content of the arbitration agreement must contain when there is a payment dispute between two MHPs that the affected MHPs are notified of the arbitrator's decision. Providers would not be affected by the outcome of any arbitrator's decision.

1850.415 Implementation of the Arbitrators' Decision

Comment: CHA-46 and CPA-42 comment that providers should be included in the notification of decisions.

Response: Please see the response to the comment on Section 1850.405.

1850.505 Requests for Resolution

1850.505(a)

Comment: CHA-47-a comments that providers of service should be permitted to submit a request for resolution to the Department.

Response: While acknowledging the impact such disputes may have on providers, the department believes that the resolution of disputes between MHPs and Medi-Cal Managed Care Plans is outside the purview of a provider's activities and responsibilities.

1850.505(a)

Comment: CHA-47-a comments that providers of service should be included in the notification of decisions.

Response: This section establishes the specific procedures through the Department of Mental health and Health Services to resolve disputes between

MHPs and Medi-Cal managed care plans only. This process is not amenable to the resolution of disputes between providers and MHPs therefore, it is not necessary to include providers as recommended.

1850.520 Department's Decision

Comment: CHA-48 comments that they believe providers of service should be included in the notification of decisions.

Response: See the response to the comment on Section 1850.505(a).